STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035216	A. BUILDING _____ B. WING _____	**12/15/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARING HOUSE	**PO BOX 2187 SACATON, AZ 85247**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0582 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on record review and interview, the facility did not ensure that residents were informed at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. Finding includes: For three of 3 residents who were discharged home after a Medicare covered part A stay with benefit days remaining, the facility was unable to provide documentation that the residents were provided, and had acknowledged receipt of, the Skilled Nursing Facility Advanced Beneficiary Notice prior to providing care that Medicare usually covers but may not pay for because the care was not medically reasonable and necessary or was considered custodial. During an interview on 12/14/17, a facility administrative staff member (38) stated that no notices had been issued and that the facility had not developed their specific notification form. (Reference Residents 277, 278, and 279)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, record review, and interviews, the facility failed to fully investigate an injury of unknown origin for one of three residents (Resident 13) who were investigated for abuse, neglect, exploitation, or mistreatment, out of a total of 24 sampled residents. Finding includes: According to the Resident Face Sheet, Resident 13 was admitted to the facility on [DATE] and resided on unit A (secured dementia unit). Resident 13's pertinent [DIAGNOSES REDACTED]. Resident 13's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed under Section B, Hearing, Speech, and Vision that Resident 13 was rarely or never understood. Section G Functional Status documented that she required extensive assistance of two staff members for bed mobility, transfers, dressing, toileting and personal hygiene. Resident 13 required extensive assistance of one staff member for eating and locomotion on and off the unit. Section [NAME] Behaviors documented she had other behavioral symptoms not directed toward others on a daily basis (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). An Event Report dated 9/14/17 at 4:00 p.m., revealed that during shower staff had observed that Resident 13's left upper arm was discolored. Orders were obtained to monitor the left upper arm discoloration for changes every shift. The report failed to reveal a description of the discoloration including size and shape, or document whether or not Resident 13 had been assessed by a registered nurse. There was no evidence that the resident had been assessed regarding a change in condition related to her injury of unknown origin. The IDT (Interdisciplinary Team) Report/Root Cause Follow Up report for Resident 13 dated 9/14/17 at 4:00 p.m., documented, nurse noted on shift a light brownish color discoloration to residents left upper arm. Resident has a history of bumping into walls, doorway, aimlessly rolling through unit with w/c. Resident also has a history of fragile skin, easily bruising and poor vision with skin discoloration. The related [DIAGNOSES REDACTED]. The recommendations were to continue to redirect the resident, staff were to continue to monitor behavioral issues for resident's safety. The interventions initiated included long sleeve clothing and padding on wheelchair. Under the section titled Care Plan created: there was a note that documented, care plan already in place for skin integrity including skin discoloration. The IDT report failed to indicate that an investigation to rule out potential abuse, neglect or mistreatment was conducted by the facility. The Resident Progress Note dated 9/14/17 at 4:02 p.m., read During care resident observed with discoloration to left upper arm, resident without s/s (signs and symptoms) of pain/discomfort at this time. Orders to monitor for changes. Resident with fragile skin, mobile via w/c (wheelchair) aimlessly rolls through unit and at times bumps into walls (sic) staff redirects when possible, measures in place to help minimize skin issues such as padded w/c and long sleeve clothing. Review of the physician's Telephone Orders dated 9/14/17 revealed that Resident 13 had discoloration to the left upper arm, and staff were to monitor for changes every shift. A second order dated 10/8/17 (24 days after first being identified) documented, discontinue left upper arm discoloration monitor for changes every shift - resolved. Review of the Weekly Skin Observations dated 9/12/17 through 10/3/17 revealed the following: - 9/12/17: resident noted with bruising that was described as old ecchymosis to bilateral upper and lower extremities fading and chronic. - 9/17/17 - 9/23/17: no weekly skin observation was completed during this week. - 9/26/17: resident noted with old faded discoloration to bilateral upper extremities, chronic. - 10/10/17: resident noted with bruising described as old discoloration to bilateral upper arms, dark faded elbows. Further review of the Resident Progress Notes from 9/14/17 - 9/28/17 failed to reveal that a change in the resident's condition (i.e. discoloration to left upper arm) was assessed by a registered nurse. Additionally, the progress notes dated 9/12/17 through 9/15 failed to reveal Resident 13 displayed any behaviors. The impaired skin integrity Care Plan initiated on 7/5/17 and edited on 12/14/17, indicated Resident 13 was at risk for impaired skin integrity related to frequently sustaining skin tears and bruises to bilateral hands and arms as a result of agitated episodes of pushing, banging, slapping of hands on the table, frequently rubbing hands, wandering in wheelchair (w/c) and bumping into door ways. A revision on 9/14/17 documented that the resident had a left upper arm discoloration. The care plan interventions documented that the resident's skin tears and bruises easily, staff were to thoroughly dry skin after bathing and as often as needed, pay special attention to skin folds and opposing skin surfaces, pat skin dry rather than rubbing it, pad the legs of w/c to prevent legs from bumping rubbing or hitting w/c when self-propelling. Staff were to check placement of the padding every shift, tubi-grip to bilateral upper arms to protect skin from injury, remove every shift to check skin. Determine risk for skin breakdown by performing the Braden Risk Assessment tool, inspect skin weekly for pallor, redness, and breakdown and record the findings on the skin observation form. Further documentation directed staff to maintain optimal nutrition, moisturize skin during routine care at least once daily, monitor for signs and symptoms of dependent [MEDICAL CONDITION], and alert wound care team if resident is in need of [MEDICAL CONDITION] management. Further review of Resident 13's care plans revealed a Cognitive loss/dementia care plan, initiated on 9/30/17, which indicated that the resident pushes on tables which in the past has led to agitating other residents. The short-term goal

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) was to protect the resident from becoming a victim of physical or verbal aggression from other residents. The care plan approaches directed staff to move Resident 13 to a separate table by herself if agitation was observed to keep her and other resident's safe. If the resident had an episode of aggression staff were to assess the resident for injury, notify physician and family of incident, and if agitation of another resident is noted, separate the resident. On 12/15/17 at 10:28 a.m. a request to speak to the nurse who completed the incident event report on 9/14/17 was made. An administrative nursing staff member (Staff 190) stated that she called the nurse and asked her to call the facility. The nurse had not called the facility for an interview by the time the survey team exited the facility on 12/15/17. During an interview with the the same staff (190) on 12/15/17 at 10:28 a.m. she stated that she was new to her position and was not at the facility when this issue occurred. She stated that the previous DON and administrator both resigned at the same time. Staff 190 stated that she was unable to find an investigation other than the event and IDT report. However, she stated that she would not consider the discoloration to the residents left upper arm as an injury of unknown origin based on the documentation and resident's behaviors which were care planned. The same staff (190) stated the current practice was for nurses to fill out the incident report and if needed the skin team (wound team) would updated the resident's care plan, assess, and investigate. She added that all staff have been educated as of this morning (12/15/17) to make sure they document that they have interviewed their staff to rule out abuse. An interview was conducted with a certified nurse aide (CNA 59) on 12/14/17 at 11:57 a.m. She stated she noticed the discoloration to Resident 13's skin and reported it to the nurse. She stated that the resident gets agitated at times and has behaviors. In regards, to the discoloration CNA 59 thought that the resident could have bumped into something, but CNA 59 had not witness any incident that would have created the discoloration. She added that when she sees something (i.e. changes in skin condition) she reports that change to her nurse. The CNA stated that at this time (3 months after identifying the discoloration) she was unable to describe what the discoloration looked like or what size it was when she first discovered it. During a separate interview with CNA 72 on 12/15/17 at 12:37 p.m. she stated that she worked on 9/14/17; however, she was not aware of any skin issues for Resident 13 and does not remember identifying or reporting a skin issue for the resident to the nurse. Policy Review of the facility policy titled, Gila River Health Care - The Caring House Abusing Investigation and Reporting (last revised 9/2017) revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Role of the Administrator: 1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the administrator will assign the investigation to an appropriate individual. 2. The administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. 4. The administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation 5. The administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. 6. The administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. Role of the Investigator: 1. The individual conducting the investigation will, at a minimum: a) Review the completed documentation forms. b) Review the residents medical record to determine events leading up to the incident. c) Interview the person(s) reporting the incident. d) Interview any witnesses to the incident. e) Interview the resident (as medically appropriate). f) Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition. g) Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. h) Interview the resident's roommate, family members, and visitors. i) Interview other residents to who the accused employee provides care or services, and j) Review all events leading up to the alleged incident.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement a comprehensive assessment for two of 15 sampled residents (Residents 125 and 1). Findings include: 1. Record review on 12/15/2017 revealed that Resident 125 was admitted on [DATE] to the facility with hypertension, fracture of [MEDICATION NAME] vertebrae, diabetes type 2, chronic obstruction [MEDICAL CONDITION] disease, and obesity. Resident 125 developed a facility acquired pressure ulcer/injury on 11/28/2017 according to the skin assessment and interdisciplinary team (IDT) meeting held on 11/29/2017. The minimum data set (MDS) comprehensive assessment completed on 12/7/2017 failed to capture that the resident had an active pressure ulcer/injury. During a record review concurrent with an interview on 12/15/2017 at 12:15 p.m., in regards to the resident's comprehensive assessment dated [DATE], Section M - skin Conditions, a licensed staff member (219) acknowledged that Section M of the assessment was left blank although Resident 125 had an active pressure ulcer/injury. The blank areas in Section M of the MDS included: -M0300 - current number of unhealed Pressure ulcer at each stage, -M0610 - Dimensions of unhealed stage 3 and 4 pressure ulcers or eschar. -M0700 - Most severe Tissue Pressure ulcer -M0800 - Worsening on pressure ulcer status since prior assessment Staff 219 also indicated that the wound care lead completed section M - Skin Conditions of the comprehensive assessment. She further explained that she does not validated the entry from other disciplines, although she signs off on the completion of the comprehensive assessment dated [DATE]. During a record review concurrent with an interview on 12/15/2017 at 2:00 p.m., a licensed staff (Staff 180) acknowledged that Section M was not completed and indicated that she was out sick and that another licensed staff (Staff 182) completed section M of the MDS. She indicated that the comprehensive assessment dated [DATE] should have captured the current stage 3 and unstageable facility acquired pressure ulcer/injury for Resident 125. 2. Resident 1 was admitted on [DATE] with several [DIAGNOSES REDACTED]. The facility entered an admission MDS dated [DATE]. The resident was discharged home on[DATE]. There was no discharge MDS assessment completed. During an interview on 12/16/2017 at 2:00 p.m., when asked about this, a licensed staff (Staff 186) stated that the discharge MDS should have been sent to CMS within 14 days of the discharge. She stated she could not find a discharge MDS assessment for the resident. Review of the facility policy #NSG103.04 titled, Electronic Transmission of the MDS (revised 9/2017) read in pertinent part as follows:

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F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records shall be completed and electronically encoded into The Caring House's MDS information system and transmitted to the CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data. Review of the policy # NSG103.05 titled, MDS Completion and Submission Timeframes (revised 9/2017) read in pertinent part as follows: .2. The following timeframes shall be observed: Assessment type: .Discharge Assessment Return NOT anticipated (non-comprehensive) .MDS completion date: discharge date + 14 calendar days .Transmission Date: MDS Completion date + 14 calendar days .
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement a baseline care plan for pain management, diabetes mellitus, [MEDICAL CONDITIONS], and constipation for 1 of 15 sampled residents (Resident 127). Finding includes: During an observational tour concurrent with an interview on 12/11/2017 at 2:15 p.m., Resident 127 was screaming out loud while in her bed. During the tour, a licensed staff member (Staff 193) was asked why Resident 127 was screaming so loud. Staff 193 responded that Resident 127 was newly admitted and that she maybe having behavior concerns, pain, and possible constipation. Staff 193 requested for another staff member to attend to resident. During a record review concurrent with an interview on 12/14/2017 at 8:48 a.m., with Staff 193, she validated that the resident did not have a baseline care plan for pain management, diabetes management and [MEDICAL CONDITION], and constipation. Further review of the clinical record revealed that Resident 127 had an AV shunt (a [MEDICAL TREATMENT] access) on the left arm and receives [MEDICAL TREATMENT] on Mondays, Wednesdays and Fridays, according to the physician orders. The Medication Administration Record [REDACTED]. In addition Staff 193 confirmed that Resident 127 had received medication for constipation which may have contributed to her discomfort. During an interview concurrent with a record review on 12/14/2017 at 9:48 a.m., an administrative nursing staff member (Staff 190) indicated that Resident 127 was admitted on [DATE] with diabetes mellitus, [MEDICAL CONDITION], septic left knee, and pressure ulcer. Staff 190 acknowledged the physician orders [REDACTED]. Staff 190 further explained that the care plan dated 12/09/2017 failed to include baseline problems, goals or approach for bowel management, diabetes management, [MEDICAL TREATMENT] care and pain management. In addition Staff 190 indicated that the base line care plan was to be initiated upon admission, and that the facility will be providing in-service to the license staff. Review of the policy entitled, Care Plan Comprehensive Procedure revealed: 1). The Caring house will establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning is intended to drive the type of care and services that a resident receives.
F 0656 **Level of harm** - Actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility did not develop and implement a comprehensive person-centered care plan for each resident. (Residents 55, 13, and 125) Findings include: 1. Resident #55 was admitted on [DATE] with multiple [DIAGNOSES REDACTED]. Review of the initial minimum data set (MDS) assessment dated [DATE], Section J1700, noted the following: Fall History on admission in the last month=(None); Falls in the last 2 - 6 months = (None): Fracture related to falls in the last 6 months prior to admission = (None). Further record review revealed that a significant change in condition assessment was conducted on 5/10/17, and under Section J1800 listed, Falls since admission = Yes; and section J1900 number of falls since admission = Two or more; Injury = NONE: Major Injury = Yes. A quarterly assessment dated [DATE] - Section J1800/1900 indicated the the resident had One fall since 5/10/17 with no injuries: The most recent quarterly assessment dated [DATE] under Section J1800/1900 noted: One fall since 8/10/17 no injury. During the initial tour of the facility on 12/11/17 at 4:05 p.m., Resident 55 was observed sitting in a recliner chair in the main living area with his eyes closed. He had on regular shoes. A licensed staff member (Staff 191) stated that the resident used a wheelchair for mobility. Observation of the resident's room showed a private room with fall mats observed beside both sides of bed, and the bed was in the lowest position. During an interview on 12/13/17 at 2:17 p.m., when asked how long she had known and worked with Resident 55, a certified nurse aide (CNA 59) stated that she had worked with the resident since his admission approximately 11 months ago. CNA 59 stated that due to his cognitive impairment the resident did not remember that he could not walk, that he tried to get up but then fell down because he was weak. CNA 59 added that they kept a close watch on him even when he was in his room at night, but sometimes, however, staff had to step away and even if its just for a minute, the resident would sometimes just get up and then would fall. When asked what happened when the resident broke his nose, Staff 59 stated, When he fell and broke his nose in (MONTH) (2017), he had rolled out of his bed. It was in the low position, but we did not have fall mats beside the bed at the time. Right after that the fall mats were placed. During the survey on different days, review of Resident 55's medical record revealed the following: In the Matrix electronic health record (EHR) was a section titled: EVENTS which were reports of incident that occurred to the resident. A report dated 12/10/2017 at 9:00 p.m., indicated that the resident fell out of his wheel chair; however did not sustain an injury. A review of EHR revealed a care plan for falls initiated 2/8/17 and revised 12/11/17. Under the Problem was noted At risk for falls indicating a list of falls with the following dates: a. 2/28/2017 - no injury (NI). Review of the progress notes dated 2/28/17 at 9:57 p.m. read that the resident was found on the floor and was sent to the emergency room (ER) for evaluation and treatment. The resident returned from the emergency room (ER) on 3/1/17 at 4:29 AM. The results of an x-ray examination showed a [MEDICAL CONDITION] elbow. Accordingly, while the staff placed the bed in low position; however, the care plan was not updated. b. 3/6/17 and 3/11/17 (no injuries) - No details of these falls were found and the care plan was not updated. c. 4/24/17 listed a witnessed fall and [MEDICAL CONDITION] after the fall. Resident 55 was sent to ER however sustained no injury. d. 5/18/17, the resident fell and sustained a skin tear to right forehead. e. 5/22/17 - the resident fell out of bed and sustained a laceration and fracture to bridge of nose, and laceration to the upper lip. f. 6/9/17 - the resident fell out of bed; however sustained no injury. g. 12/10/17 - the most recent fall was dated; the resident fell out of his wheel chair on the way to his room. There were no updates to the care plan for the above falls. A care plan for [MEDICAL CONDITION] activity with the problem, At risk for accident/injury was initiated on 2/13/17 (and revised 11/30/2017). The following was listed under problem: Had [MEDICAL CONDITION] during therapy on 4/24/2017. The goal listed, Resident will remain free from injury r/t (related to) [MEDICAL CONDITION], and maintain therapeutic levels of anticonvulsant medication through next review date 5/13/2017.

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F 0656 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) Interventions included monitor for [MEDICAL CONDITION] activity and report to physician; monitor Labs for therapeutic levels of anticonvulsant medication; provide safe environment during [MEDICAL CONDITION] activity (if it occurs), and try to maintain resident in side-lying position; and monitor for s/s (signs and symptoms) of aspiration of any emesis. On 11/30/17, the following was added to the interventions: [MEDICAL CONDITION] precautions: bilateral floor mats on each side of residents bed and report changes in cognition or behavior to MD. 12/14/17 at 3:48 p.m., during an interview, when asked for the investigation of the 8 falls the resident had sustained, a nursing administrative staff member (Staff 190) stated that there were no investigations prior to the 12/10/2017 fall. During a concurrent record review of the Event Report and care plan for the fall risk, Staff 190 stated that when the Event Report indicated the care plan was updated the staff listed the date of the new fall on the problem list; but they did not update the goals or the interventions for Resident 55 despite the resident having 8 falls including 2 major injuries and one minor injury. 12/15/17 10:14 a.m., during an interview, when asked how long the staff had worked at the facility, a licensed staff member (Staff 186) stated she had worked at the facility in her position for about 3 years. When asked how she was trained for the MDS coordinator position, Staff 186 stated it was on-the-job training by the previous MDS coordinator. When asked what she did with the care plans/assessments for falls, Staff 186 stated said she trained the nursing staff to update the care plan as needed, and explained that the facility did not have a fall committee or meet after each fall. Staff 186 stated that the IDT (interdisciplinary team) developed the care plans as a team, that the IDT used care plan books for ideas on creating care plans, and that the IDT met every Thursday and discussed the care plans together. Staff 186 also stated that the nurses should have been updating the care plans after each fall. During the concurrent review of the fall care plan for Resident 55, Staff 186 acknowledged that the problem statement for the falls did not list the problem, the goal was not individual or measurable and the interventions listed were not individualized and did not take into account the resident's cognitive impairment. There were no changes to the goals, or interventions after the falls the residents sustained. 2. According to the Resident Face Sheet, Resident 13 was admitted to the facility on [DATE], and resided on unit A (secured dementia unit). Resident 13's pertinent [DIAGNOSES REDACTED]. During observations on 12/12/17 at 2:50 p.m. and 12/13/17 at 8:10 a.m. Resident 13 was observed to have missing teeth, and broken teeth that were dark in color. Resident 13's annual minimum data set (MDS), a standardized screening and assessment tool used for long term care residents dated 7/1/17, indicated under Section L (Oral/Dental Status), the the resident had obvious or likely cavities or broken natural teeth (cross refer F791: Emergency/Routine Dental Services). Another MDS dated [DATE] indicated, under Care Area Assessment Summary (CAA) for Section L, that the resident had natural teeth; however, some teeth were missing and broken. The documentation noted that the resident's gums and tongue were pink and moist, that there was no indication her teeth were causing any pain or discomfort, and that she was meeting her nutritional needs. Further documentation indicated that the resident was unable to answer any questions and responded by mumbling. The documentation also noted that oral care was provided by nursing personnel due to Resident 13's inability to perform steps to provide her own oral care, and that she was unable to understand instructions related to her cognition. The resident's lips were noted as being dry and chapped, and that due to her advanced age and cognition, she would see the dentist as needed because she was unable to follow instructions or cooperate for a dental consult. The documentation further indicated that the dentist would be consulted if the Resident 13 developed any oral [MEDICAL CONDITION] or ulcerations or had trouble chewing. The resident was noted as being on a mechanically altered diet. The decision to care plan this care area was marked Yes. A review of Resident 13's comprehensive care plans, last reviewed and revised on 10/05/17, failed to reveal a comprehensive care plan had been developed to address the resident's dental status or dental care needs. Resident 13's comprehensive care plans were reviewed with a social service staff (Staff 223) on 12/13/17 at 4:02 p.m. Staff 223 verified that the facility failed to develop a comprehensive care plan for the resident's dental status and dental care needs. Staff 223 added that the MDS nurse was responsible for assessing and care planning the resident's dental status or dental care needs. On 12/14/17 at 8:24 a.m., a review of Resident 13's comprehensive care plans was conducted with a licensed staff member (Staff 180) and revealed that there was no care plan related to the resident's dental status or dental care needs. During an interview on 12/14/17 at 8:24 a.m., Staff 180 stated that she thought the resident had a dental care plan that may have been deleted in error; however, she was not able to find a discontinued care plan related to the resident's dental status or care. She added that the dental section was a new section of the MDS assessment for her to complete, and she was still learning. She also stated that if she saw a resident had broken teeth or issues that needed attention, she would initiate a care plan. Staff 180 stated, if a resident did not have teeth or needed help with dental care, she would create a care plan. She stated she was not sure how she missed initiating a care plan especially because the resident could not take care of her own teeth. She acknowledged there should have been a dental care plan in place to direct care for Resident 13's dental needs. On 12/15/17, a request for the facility's policy related to dental services was made; however, one was not provided prior to the end of the survey. 3. Record review on 12/15/2017 revealed that Resident 125 was admitted on [DATE] to the facility with several [DIAGNOSES REDACTED]. The minimum data set ((MDS) dated [DATE] documented that Resident 125's 14-day assessment BIMS (brief interview of mental status) score was 15 which indicated no cognitive impairment. According to the skin assessment, the resident developed a facility acquired pressure ulcer/injury to the coccyx and buttocks area on 11/28/17. Further record review revealed that the facility failed to initiate a patient centered care plan with interventions for the facility acquired pressure ulcer/injury from 11/28/2017. As a result the resident's pressure ulcer/injury had evolved to an unstageable wound on the left buttock, and a stage 3 pressure ulcer on the right buttock, according to the clinical record. During an interview on 12/14/17 at 10:12 a.m., Staff 180 validated that the pressure ulcer/injury was facility acquired and that Resident 125 was admitted with intact skin, according to the admission skin assessment conducted on 11/18/17. Staff 180 added that the facility expectation was to update the care plan as soon as an issue was identified. The staff also acknowledged that the care plan was not updated for the resident's pressure ulcer/injury when it was identified. According to the facility policy reviewed on 12/14/17 titled, Care Plans - Comprehensive, revealed that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was to be developed for each resident.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that the resident's care plan was reviewed and revised after each assessment. Finding incudes: 1. Resident 8 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. The quarterly MDS (minimum data set) assessment completed on 9/20/17 noted that the resident had a BIMS (brief interview of mental status) score of 15 indicating he had no cognitive impairment. The MDS also noted that Resident 8 required extensive assistance with most activities of daily living but was independent with locomotion on and off the unit using his wheelchair. During an interview at 3:18 p.m. on 12/11/17, Resident 8 stated that he had a fall a couple of months ago while he was at an outpatient clinic for an appointment. The resident explained that he was propelling his wheelchair up a ramp to the clinic when his wheelchair tipped over causing him to fall. According to the resident, he was transferred to a hospital emergency room for further evaluation and returned to the facility several hours later. After the fall, the resident recalled that his [MEDICATION NAME] area was injured and that his head and back ached. A post-fall assessment by the facility on 10/12/17 revealed that the resident was wheeling up a steep ramp at an outpatient

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) clinic when his wheelchair tipped backwards. Accordingly, the anti-tip device did not hold and the wheelchair fell sideways and hit (a) pillar. The fall resulted in the transfer of the resident to the emergency room of an acute care hospital via 911. A CT scan of the spine revealed that the resident had sustained mildly displaced acute [MEDICAL CONDITION] anterior aspect of the 10th [MEDICATION NAME] vertebrae. The scan report further noted that the resident had complained of back pain after the fall, as well as posttraumatic headache as was noted on the report of the CT scan of his head. Review of the medical record revealed that in spite of the fall, there was no indication that the resident's care plan was reviewed and revised to ensure that interventions were developed and in placed. The resident's care plan for falls was initiated on 10/13/15 related to the resident's lower extremity muscle spasms. Interventions developed included use of [MEDICATION NAME] (a drug to treat spasms) for spams/cramps; keeping the call light in reach of the resident at all times; and keeping personal items and frequently used items within reach. There was no indication that the care plan was evaluated and revised to ensure that it was adequate and addressed the resident's need for a safe environment in keeping with his functional limitations and need for independence. There was no mention of the fall in the care plan and current interventions did not include how the etiology cause of the recent fall could be addressed or removed to prevent further falls. 2. Resident 25 was admitted on [DATE] with [DIAGNOSES REDACTED]. The minimum data set (MDS), an assessment tool for each of the assessments for the last year showed a BIMS of 3 indicating the resident had significant cognitive impairment and needed moderate assistance with activities of daily living (ADLs). During a family telephone interview conducted on 12/12/17 at 11:29 a.m., when asked if the resident had ever fallen, the family member stated that Resident 25 had fallen at home a lot and was one reason why she was admitted to skilled nursing facility. The family member added that Resident 25 had a fall at the facility earlier this year (in (YEAR)), and that the facility had called her to let her know. Accordingly, the facility told her they found Resident 25 on the floor in the night. She had real bad bruises. Her whole left side of her face was bruised. She forgets that she can't walk anymore and then falls. Review of the resident's electronic medical record during the survey revealed, under Events, a note dated 11/01/16 at 12:39 a.m., that read in pertinent part as follows: Found on floor no pain, said she hit her head. Had reddish knot on right side of head & abrasion to R. (right) elbow. Under PROGRESS NOTES, the following entry read in pertinent part as follows: 4/18/2017 (12:05 a.m.) On 4/17/17 at (11:35 p.m., a CNA found the resident laying on the floor with a bump to the L(eft) forehead, unwitnessed fall, resident alert but confused, stated she 'hurt my head', assessment done, MD (doctor)and (responsible party) notified, sent to the ER via ambulance. (Resident 25) complained of pain to L forehead. When returned from theER on [DATE] at 12:30 p.m., the (resident) had bruising to under right eye, lump and left forehead, eye and cheek, left eye closed with swelling. Was found to have a UTI (urinary tract infection). (Face) Painful to touch but refused pain medication Monitoring and neuro checks conducted A care planning conference was conducted with the resident's family members on 4/20/17. However, there were no changes to the care plan and no documentation as to why the care plan remained the same despite the injury the resident had sustained. Review of EVENTS documentation showed only one fall incident report on 11/1/2016. There was no Event report documented for the 4/17/17 fall. On 12/14/17 at 11:45 a.m., during an interview requesting information on the resident's fall incidents, a medical records staff member (Staff 188) provided a care plan for falls that indicated the resident had four falls in the past year on the following dates: a. 10/01/16 - no information documented; b. 11/01/16 - no injuries, c. 2/15/17 and 4/17/17 - with head injuries. The care plan did not include changes/revision or updates after two of the four falls which were on 10/01/16 and 2/15/17. On 12/14/17 at 10:43 a.m., when asked if the facility had conducted fall risk assessments, progress notes; care plan updates, or if any any hospital records were available for the falls dated 11/01/16, 2/15/17 and 4/17/17, Staff 188 provided the following; Fall Risk scores above 10 means the resident was at High Risk for falls. Fall Risk assessments for the following dates revealed the following scores: 10/14/16 =21; 2/07/17 score =16; 4/07/17 = 24; 7/13/17= 22; 10/13/17= 20; and 11/19/17 = 14. These scores indicated the resident was at continued high risk for falls. Review of the MDS revealed the following in pertinent part: Quarterly assessment dated [DATE] under Section J1700, 1800/1900 indicated the resident had no falls since previous assessment. A Care Plan for falls was in place with an initial date 1/29/2016. There were no updates after the fall documented on 10/1/2016. Annual assessment dated [DATE] under Section J1800 /J1900 indicated the resident had 2 or more falls with no injuries and 2 or more falls with minor injuries. While a care plan was in place with a start date of 11/01/16, the interventions, however, were the same as on 1/29/16. The goal was not changed even though Resident 25 had four or more falls in the previous look back period. Quarterly assessment dated [DATE] under Section J1800/ J1900 indicated that Resident 25 had one fall with minor injury since the previous quarter. A care plan was in place with start date 12/06/15 with revision dated 2/16/17 - the goal was the same; although the target date changed to 4/1/2017. Further, while the resident had fallen with a head injury, the facility removed and did not replace the following interventions: utilize pressure sensor when not in bed ; provide environmental adaptations; low bed, call light within reach, adequate glare free lighting; area free of clutter; Remind resident and reinforce safety awareness; and report to MD side effect associated with resident's medication use. The intervention Reminding and reinforcing safety awareness was not relevant to Resident 25 due to her cognitive impairment. Quarterly assessment dated [DATE] under Section J1800/ J1900 indicated the resident had one fall with minor injury since the previous quarter. The fall was dated 4/17/17 and resulted in a head injury. The care plan was in place with the same goals and added intervention to keep personal items and frequently used items within reach; observe frequently and place in supervised area when out of bed; occupy resident with meaningful distractions; music, companion, crafts, etc. Because the resident was unable to obtain personal items for herself, this intervention was not meaningful to the resident. In addition, the intervention to observe the resident frequently when out of bed does not address the resident falling out of bed. Quarterly assessment dated [DATE] under Section J1800 indicated that the resident had no falls in the previous quarter. The care plan was in place with the same goal; above interventions continued and the facility restarted interventions that had been removed in (MONTH) (YEAR). 3. Resident 55 was admitted on [DATE] with multiple [DIAGNOSES REDACTED]. Review of the minimum data set (MDS - an assessment tool) initial assessment dated [DATE] under Section J1700 listed, Fall History on admission in the last month=(None); Falls in the last 2 - 6 months = (None): Fracture related to falls in the last 6 months prior to admission = (None). On 5/10/17, a significant change in condition assessment was conducted, and under Section J 1800, the following was noted: Falls since admission = Yes; and section J1900 number of falls since admission = Two or more; Injury = NONE: Major Injury = Yes. A quarterly assessment dated [DATE] - Section J1800/1900 indicated, One fall since 5/10/17 with no injuries. The most recent quarterly assessment dated [DATE] under Section J1800/1900 noted: One fall since 8/10/17 no injury. During the initial tour of the facility on 12/11/17 at 4:05 p.m., the resident was observed sitting in a recliner chair in the main living area with his eyes closed. He had on regular shoes. A licensed staff member (Staff 191)stated that Resident 55 used a wheelchair for mobility. Observation of the resident's room showed a private room with fall mats observed beside both sides of bed which was in the lowest position. 12/13/17 at 2:17 p.m., when asked how long she had known and worked with Resident 55, a certified nurse aide (CNA 59)stated she had worked with the resident since his admission approximately 11 months ago. CNA 59 added that due to his cognitive impairment, the resident did not remember that he could not walk, that he tried to get up but then fell down, because he

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) was weak. CNA 59 explained that they kept a close watch on him, even when he was in his room at night, but sometimes, the staff had to step away and even if was just for a minute, the resident would just get up and then would fall. When asked what happened when he broke his nose, Staff 59 stated, When he fell and broke his nose in (MONTH) (2017), he had rolled out of his bed. It was in the low position, but we did not have fall mats beside the bed at the time. Right after that the fall mats were placed. During the survey on different days review of Resident 55's electronic medical record revealed the following: Under EVENTS of Matrix, the electronic record, was a section where reports of incidents that occurred to the resident were listed. A report dated 12/10/2017 at 9:00 p.m. indicated that the resident fell out of his wheel chair but did not did not sustain an injury. A review of EHR showed a care plan for falls initiated on 2/8/2017 and revised on 12/11/2017. Under the Problem where the resident was At risk for falls, a list of falls with the following dates were noted: a. 2/28/2017 - no injury (NI) - Review of the progress notes dated 2/28/17 at 9:57 p.m. revealed that Resident 55 was found on the floor and was sent to the emergency room (ER)for evaluation and treatment. He returned fromER on [DATE] at 4:29 a.m. The results of the X-ray showed a [MEDICAL CONDITION] elbow. The staff placed the bed in low position; however the care plan was not updated. b. 3/6/17 (No injury)and 3/11/17 (no injury)- No details of these falls were found and the care plan was not updated. c. 4/24/17 listed as witnessed fall and [MEDICAL CONDITION] after the fall. Resident 55 was sent to ER; however was noted as having no injury. d. 5/18/17- the resident fell and sustained a skin tear to right forehead. e. 5/22/17 - fell out of bed and sustained a laceration and fracture to bridge of nose, and laceration to the upper lip. f. 6/9/17 fell out of bed; however sustained no injury. g. The most recent fall was dated 12/10/17; fell out of his wheel chair on the way to his room. There were no updates to the care plan for the above falls. On 12/14/17 at 3:48 p.m., during an interview, when asked for the investigation of the 8 falls unrelated to [MEDICAL CONDITION] the resident sustained [REDACTED]. Concurrent record review of the Event Reports and care plan for fall risk, Staff 190 stated that when the Event Report indicated the care plan was updated, the staff listed the date of the new fall on the problem list. They did not update the goals or the interventions for Resident 55 despite the resident having 8 falls including 2 major injuries and one minor injury. On 12/15/17 at 10:14 a.m., when asked during an interview how long the staff had worked at the facility, a licensed staff(Staff 186)stated that she had worked at the facility in her position for about 3 years. When asked how she was trained for the MDS coordinator position, Staff 186 responded that it was an on-the-job training by the previous MDS coordinator. When asked what the she did with the care plans/assessments for falls, she stated that she trained the nursing staff to update the care plan as needed. She also explained that the facility did not have a fall committee or meet after each fall. Staff 186 stated the Interdisciplinary Team(IDT)developed the care plans as a team, and that they used care plan books for ideas on creating care plans. The IDT met every Thursday and discussed the care plans together. Staff 186 added that nurses should have been updating the care plans after each fall. Following the concurrent review of the fall care plans for Residents 55 and 25, Staff 186 acknowledged that the problem statement for the falls did not list the problem, that the goal was not measurable, and the interventions listed were not individualized and did not take into account the residents' cognitive impairment. There were no changes to the goals, or interventions after the falls the residents sustained. Review of the policy in place at the time of the above falls titled Falls and Fall Risk, Managing dated from 2001 MED-PASS, inc (revised (MONTH) 2007) read in pertinent part as follows: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation; Prioritizing Approaches to Managing Falls and Fall Risk read in pertinent part as follows: .4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 5. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling until falling is reduced or stopped, or until the reason for the continuation of the falling is identified and unavoidable. 6. in conjunction with the Attending Physician, staff will identify and implement relevant interventions . to try to minimize serious consequences of falling. 4. According to the quarterly minimum data set (MDS) assessment (a comprehensive assessment performed in nursing homes), dated 7/12/17, Section C (cognitive status) of the MDS assessment revealed Resident 24 was cognitively intact as evidenced by a brief interview for mental status score of 15 out of 15 (score of 13-15 indicates cognitively intact). Resident 24 required extensive assistance from two staff for transfers and extensive assist from one staff for bed mobility, locomotion on/off the unit, toileting, and personal hygiene. Resident 24 had falls prior to his admission or previous MDS assessment (whichever was more recent). According to the progress note, dated 5/24/17, the medication nurse discovered Resident 24 on the floor in front of his wheelchair. The resident returned from having a haircut. When the resident was asked what happened, staff asked Resident 24 if he tried to get up and into bed. The resident replied yea. the resident did not call for assistance. It appeared that the resident must have slid down and was found sitting. He was noted with scratches to his right elbow measuring 0.4 x 0.4 centimeters (cm) and 0.5 x 0.3, with no bleeding noted. The note also indicated that there was a 3.2 cm scratch noted on the left side of the resident's back with no bleeding noted. The note revealed that the wound nurse cleaned the areas and applied [MEDICATION NAME] ointment. Resident 24 denied hitting his head and neuro (neurological) checks were started. According to the Event Report, dated 5/24/17, Resident 24 had an unwitnessed fall in his room which was related to fatigue, secondary to receiving [MEDICAL CONDITION]. Resident 24 was found on the floor in front of his wheelchair after he returned from having a haircut. The event report noted the resident tried to transfer himself from his wheelchair to his bed without asking for assistance. The report further noted, It appeared that he must have slid down and was found sitting. Further review of the event report revealed the fall resulted in scratches to the resident's right elbow measuring 0.4 centimeters (cm) x 0.4 cm, and 0.5 cm x 0.3 cm and a 3.2 cm scratch on the left side of the resident's back with no bleeding. The wound nurse cleaned the area and applied [MEDICATION NAME]. The resident was noted to have mild pain (uncomfortable, annoying - usually able to carry on with daily routines, socialization or sleep), and denied hitting his head. Neuro checks were started. The event report indicated the resident's care plan was updated. According to the progress note dated 9/2/17, Resident 24 had a witnessed fall during Bingo. The resident slid down slowly from his wheelchair to the floor and he did not hit his head. The resident was noted sitting on the floor (activity room) in between his wheelchair foot rest. Foot rest removed by two certified nurse aides, who assisted to sit him up in his wheelchair, no injury noted; however, one hour later the CNA reported seeing a new scratch on the left side of Resident 24. The nurse assessed area and noted a 22 cm scratch on the patients left side of his body. Cleansed with NS, pat dry and applied [MEDICATION NAME] ointment . placed patients bed in lowest position, instructed CNAs to make it sure that patient has the dycen (sic) rubber in his wheelchair seat to prevent him from sliding down, verbalized understanding. Frequent rounds are being done to assist patient needs. Will continue to monitor. According to the Event Report, dated 9/2/17, Resident 24 had a witnessed fall during an activity at 4:55 p.m. The resident was playing BINGO in the activity room with the other residents and slowly slid from wheelchair to the floor as stated by resident and obtained 22 cm scratch from the wheelchair. The section titled Follow Up Investigation of Incident had listed under other factors: other - patient has the dycen (sic) (rubber cushion) under the pad. Review of the current (active) comprehensive care plans for Resident 24, edited 12/12/17, revealed a care plan for falls that indicated Resident 24 was at risk for fall related injury as evidenced by unsteady gait, right-sided weakness [MEDICAL CONDITION]. The care plan failed to indicate if the resident had sustained any falls while residing in the facility on 5/24/17 or 9/2/17. Further review of the comprehensive care plan failed to reveal the care plan was updated to include any interventions to prevent further falls when the resident sustained [REDACTED]. While fall interventions were updated on 9/2/17, there was no direction to staff that dycen (sic) (an initial intervention to prevent further falls, see below) was

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) supposed to be placed in the resident's wheel chair to help prevent the resident from sliding down. (Cross refer to F689 - Accidents) Review of an inactive fall care plan initiated on 4/25/17, revealed that Resident 24 was at risk for falling related to weakness to his right upper extremities and right lower extremities. the resident required extensive assistance with toileting, transfers and bed mobility. The care plan was edited on 5/24/17 to reflect an unwitnessed fall on 5/24/17 at 12:00 p.m. However, the inactive care plan was not revised to reflect any new fall interventions. The dates listed for all the care plan approaches were 4/25/17 which were discontinued on 10/17/17. During an interview with a licensed staff member (Staff 186) on 12/15/17 at 10:08 a.m., Staff 186 stated that Resident 24's care plan was in place and edited to reflect the unwitnessed fall on 5/24/17; however, review of the inactive care plan only revealed the resident sustained [REDACTED]. Staff 186 was not sure why and did not see where any interventions were initiated or implemented on the inactive care plan after the 5/24/17 fall. During an interview with an administrative nursing staff (Staff 190) on 12/15/17 at 10:10 a.m., she reported that she was newly appointed to the position and had no records for when this occurred. Staff 190 was unable to speak to the 5/24/17 fall because she was not at the facility. She reviewed the nursing notes related to the fall and did not see where any new fall interventions where initiated. Additionally, she was unable to locate an interdisciplinary note related to the 5/24/17 fall.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Findings include: 1. Resident 8 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. Review of the most recent quarterly MDS (minimum data set) assessment dated [DATE] revealed that Resident 8 had a BIMS (brief interview of mental status) score of 15 indicating he had no cognitive impairment. The MDS also noted that while the resident required extensive assistance with most activities of daily living he was, however, independent with locomotion on and off the unit using his wheelchair. During an interview at 3:18 p.m. on 12/11/17, Resident 8 stated that he had a fall a couple of months ago while he was at an outpatient clinic for an appointment. The resident explained that he was propelling his wheelchair up a ramp to the clinic when his wheelchair tipped over causing him to fall. According to the resident, he was transferred to a hospital emergency room for further evaluation and returned to the facility several hours later. After the fall, the resident recalled that his [MEDICATION NAME] area was injured and that his head and back ached. A progress note revealed that the outpatient clinic called at 2:20 p.m. on 10/12/17 to inform the facility that Resident 8 was self-propelling up the ramp and his wheelchair began to slid (sic) back and he fell out of his chair. The same note indicated that the resident was transferred to the hospital by clinic staff by 911 and that the attending physician was informed. At 10:10 p.m. (on 10/12/17), another progress note indicated that the resident returned to the facility and was medicated for a pain described as an 8 (where 10 was the most severe). Progress notes on 10/13/17 and 10/14/17 documented that the resident had no apparent injuries. Review of the medical record including the electronic record revealed the lack of documentation of any evaluation, care, or treatment rendered to Resident 8 while he was at the hospital. In addition, there was no indication that facility staff made efforts to obtain any information about the resident from the hospital to ensure continuity of care. During an interview on 12/13/17, a medical records staff member (Staff 188) stated that the facility had no hardcopy or electronic health records available for the resident while he was at the hospital. Staff 188 added, however, that copies of CT scan reports were available. Review of the documents dated 10/12/17 revealed that Resident 8 sustained a mildly displaced acute [MEDICAL CONDITION] anterior aspect of the T10 superimposed on chronic deformity. The report further noted that the resident had complained of back pain after the fall; as well as posttraumatic headache as noted on the head CT scan report. During a follow-up interview on 12/14/17 at 8:35 a.m., Resident 8 stated that he had a bad fall and was informed by the hospital physician that he had sustained a [MEDICATION NAME] fracture. Review of the medical record revealed the lack of documentation that licensed staff were aware of the scan result or that the attending physician was informed and was aware. Review of physician's progress notes revealed the lack of reference to the fall or the CT scan findings. While facility staff was aware of the fall, there was no indication that the scan results were reviewed so that the findings could be addressed, evaluated, and care planned. In addition, no considerations were made regarding referrals or consultations with other health care professionals including rehab personnel to determine whether any precautions or treatment might be warranted. Further review of the medical record including the electronic record revealed the lack of investigation of the fall particularly in the varying narratives about how the fall occurred. For example, the progress note on 10/12/17 (at 2:20 p.m.) detailing the telephone call from the clinic to the facility (as noted above) revealed that the resident was self-propelling up the ramp and his wheelchair began to slid (sic) back and he fell out of his chair. A post-fall assessment conducted on 10/12/17 following Resident 8's return to the facility however, revealed that the resident was self propelling up (a) steep (wheelchair ramp) when his wheelchair tipped backwards (has antitippers in back), and that the wheelchair tippers did not hold and (wheelchair fell sideways and hit (a) pillar. In a follow-up interview on 12/14/17 at 8:35 a.m., Resident 8 stated that while he was wheeling up the elevated ramp to the clinic, his wheelchair was unable to clear the threshold at the top (of the ramp) causing his wheelchair to tilt backwards resulting in the fall. During an interview on 12/13/17, a nursing administrative staff (Staff 190) stated the fall occurred because the resident went up the ramp in his wheelchair by himself and should have waited until he was called by clinic staff. Review of the facility's fall report and post fall assessment essentially outlined the details of the incident and the different accounts of how the fall occurred. It did not identify the cause of the fall nor did it include any findings or recommendations. In addition, there was no indication that the existing care plan for falls, developed on 10/13/15 (and edited on 9/21/17) was reviewed and revised to ensure it was effective. While the care plan noted the resident's risk for falls due to lower extremity muscle spasms, no mention was made about the recent fall and how it can be prevented. 2. On 12/12/17 at 11:35 a.m., Resident 6 was observed alert in bed. The dorsal area of the resident's right hand was observed with bluish discoloration. When asked what happened to the discolored area, she stated that she was not aware of any incident that caused the discoloration in that area of her hand. The resident was cognitively intact and answered questions appropriately. Further interview with Resident 6 related to the care in the facility revealed that a male aide who worked in the night shift handled her roughly while he assisted her transfer from the wheelchair to the bed. She stated that the aide did the transfer too fast and she felt he was in a hurry to do the task. She denied being hurt as a result of the transfer. She also stated that she saw the male aide only once and did not report the incident to the facility staff. Resident 6 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. Review of the quarterly assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 15 indicating the resident's cognition was intact. The resident's functional ability to transfer was totally dependent on staff with 2+ persons physical assist. She was also assessed to be unsteady to transfer between bed and chair or wheelchair, only able to stabilize with human assistance. The resident's Weekly Skin Observation sheet dated 12/08/17 showed no documented evidence of bruising or any bluish discoloration in the right hand. Review of the care plan dated 6/20/17 revealed the resident was at risk for abnormal bleeding or hemorrhage due to anticoagulant usage. One of the approaches stated, Monitor for and report to nurse any of the following signs and symptoms (s/s) of bleeding: bleeding gums, nose bleeds, unusual bruising tarry or black stools, red or pink or discolored urine. The physician's orders [REDACTED].>On 12/13/17 at 10:15 a.m., a licensed staff member (Staff 219) was informed of the resident's allegation of mishandling during transfer. At 4:30 p.m., Staff 219 provided an investigation of the resident's concern. The document revealed that upon interview on 12/13/17, the resident felt that when a tall male CNA transferred her

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) from wheelchair to bed, he was rough with her. The resident stated that he went too fast with the transfer. The resident was unable to recall the date when it happened and confirmed that she has not spoken with the staff about the incident. The resident confirmed that she was not hurt during the transfer and she was not afraid of the male aide. Further interview with Staff 219 revealed that she was unable to contact the aide involved and he was removed from the work schedule. She also stated that she was not aware of the bluish discoloration of the resident's right hand but confirmed the resident was receiving an anticoagulant. However, the investigation of the alleged rough handling did not include the bluish discoloration of the hand to rule out any abuse/neglect.
F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide proper treatment and assistive devices to maintain vision and hearing abilities for one of three residents (Resident 25) reviewed for hearing and vision services, out of a total of 24 sampled residents. Finding includes: Policy According to the Resident Face Sheet, Resident 25 was re-admitted to the facility on [DATE]. Her pertinent [DIAGNOSES REDACTED]. Resident 25's annual minimum data set (MDS) assessment (a comprehensive assessment completed for nursing home residents), Section B (Hearing, Speech, and Vision), dated 1/12/17, indicated Resident 25's ability to hear was coded as 1 (minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy); and her vision was coded as adequate (sees in detail, such as regular print in newspapers/books), and did not use corrective lenses (contact, glasses or magnifying glass). Section C (Cognitive Patterns) revealed the resident was rarely or never understood. Section I (Active Diagnoses) revealed the resident also had [MEDICAL CONDITIONS], or [MEDICATION NAME] degeneration. The quarterly MDS assessments, section B (Hearing, Speech, and Vision) dated 7/15/17 and 10/15/17, revealed that Resident 25 had a decline in her vision and hearing ability. The resident's ability to hear was coded as a 2 (moderate difficulty - speaker has to increase volume and speak distinctly); and her ability to see in adequate light was coded as a 2 (moderately impaired - limited vision, not able to see newspaper headlines but can identify objects). According to the 12/2017 Physician order [REDACTED]. -[MEDICATION NAME] drops 0.15%, one drop (gtt) in both eyes three times a day (TID) for [MEDICAL CONDITION] -Refresh [MEDICATION NAME] 1%, one gtt in both eyes four times a day (QID) for dry eyes -[MEDICATION NAME] ophthalmic drops 0.5%, one gtt in both eyes twice a day (BID) for [MEDICAL CONDITION] -[MEDICATION NAME] Z drops 0.004%, one gtt in both eyes at bedtime (HS) for [MEDICAL CONDITION] A clinical record review conducted on 12/13/17 at 1:28 p.m., revealed no audiology consults since the resident's original admission into the facility (11/18/11). Further review revealed one ophthalmology Referral Form dated 4/27/15. The ophthalmology findings revealed that Resident 25 had [MEDICAL CONDITIONS] and dry eyes. The progress note revealed staff were to monitor the resident and she was to return to the clinic in three months. Staff were to continue administering lubricating drops. There were no other ophthalmology consults found in the clinical record since 4/27/15, thus indicating that Resident 25 had not been seen by the ophthalmologist for any follow-up visits in more than two years. Resident 25's communication care plan dated 12/3/15, indicated that she had hearing impairments and difficulty understanding others related to dementia. The care plan failed to reveal whether the resident would or could be seen by the audiologist or whether the resident and or family desired audiology services. The resident's visual function care plan, dated 12/3/15, noted that Resident 25 had impaired vision related to [MEDICAL CONDITION]. Staff was unable to determine severity of impairment; however, the resident was coded with minimal difficulty on the annual MDS assessment dated [DATE] (see above) and with moderate difficulty on the quarterly MDS assessments dated 7/15/17 and 10/15/17 (see above). The care plan approaches included an annual optometry appointment, for staff to keep frequently used items within reach, administer eye medications and report any adverse side effects. The care plan failed to include the [DIAGNOSES REDACTED]. During an interview on 12/14/17 at 10:01 a.m., a certified nurse aide (CNA 113) stated that Resident 25 acted like she was hard of hearing, but thought this was related more to the resident's confusion than an actual hearing deficit. She stated staff anticipated the resident's needs because she was unable to make her needs known all the time. She also stated that the resident did not currently wear glasses or hearing aids. During an interview with a social service staff (Staff 223) on 12/14/17 at 11:55 a.m., she stated that unit clerks were responsible for scheduling follow-up appointments; however, the charge nurse was ultimately responsible. She added that the MDS nurse was responsible for assessing the residents vision and hearing and completing these sections of the MDS assessment. An interview with a family member familiar with Resident 25's care was conducted on 12/12/17 at 11:32 a.m. The interview revealed the resident had glasses but refused to wear them and was hard of hearing; however, no one had discussed the resident's hearing issues. An interview with a licensed staff (Staff 186) was conducted on 12/14/17 at 12:37 p.m. Staff 186 reviewed the MDS assessments dated 1/12/17, 7/15/17, 10/15/17 and acknowledged the decline in the resident's vision and hearing ability as compared to the annual MDS assessment. She stated that she did not consider them to be a decline because she did not complete the annual assessment. She stated that identified areas are discussed with the families during the care plan meetings. Staff 186 reviewed the care conference notes and was unable to show where the residents hearing and vision were discussed with the family. Staff 186 also stated that they used to document their care conference meeting notes, but now the social worker enters a note in the computer which would indicate that a care plan meeting took place and what was discussed. The staff added that that she would normally make a referral to the nurse for a decline or follow-up, but stated she did not refer this to the nurse and thinks it was just missed. A follow-up interview with a family member familiar with Resident 25's care was conducted on 12/14/17 at 1:15 p.m. The family member was not sure if the resident would understand what was going on if they were to test her hearing; however, the family member did not think the resident would act out or display any behaviors. She stated that she would like for Resident 25 to see the ophthalmologist, but was just not sure about the audiologist. The family member said they would like for the facility to at least try. The family member denied advising the facility to stop having the resident go to the eye doctor or see an audiologist. During an interview with the unit support staff (Staff 232), she stated that she did identify an issue with the resident hearing prior to going on medical leave and recommended the resident be seen and asked the family. She added that this was not documented and only learned of that when she re-submitted the request (during survey). She stated that she was out on medical leave and the clerk substituting for her was completing all the documentation; however, she stated the clerk who substituted for her while she was out on medical leave, was now out on medical leave. On 12/15/17, a request for the facility's policy related to vision and hearing services was requested; however, one was not provided prior to the end of the survey.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide care, consistent with professional standards of practice, to prevent development of pressure ulcers for 1 of 15 sampled resident (Resident 125). Finding includes: During a record review on 12/14/17, Resident 125 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. Resident 125's admission nursing assessment revealed that on 11/18/17 her skin was intact on the buttocks, coccyx and sacral area. The minimum data set ((MDS) dated [DATE] documented the resident's 14-day assessment's brief interview for mental status score (BIMS) was 15 indicating no cognitive impairments. On 11/22/17, the resident developed a blister on the upper back. On 11/28/17, an open area on the coccyx area was noted. On 12/06/17 the resident's bilateral buttocks had open areas according to the skin assessment documentation. On 12/11/17, a wound care specialist evaluated the resident and documented that the left buttock had an unstageable pressure ulcer/injury

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 8) wound, and on the right buttock, a stage 3 pressure ulcer was noted. A debridement of the wound was done at bedside and the wound measured 10 cms x 7.5 cms x 1 cm. An attempt to observe the wound and wound care was made but was not fulfilled because the resident was sent to hospital for worsening of the wound. During an interview on 12/14/17 at 10:12 a.m., a licensed staff (Staff 180) indicated that the pressure ulcers were facility acquired and that Resident 125 was admitted with intact skin. When asked to see the care plan, Staff 180 acknowledged that it was not implemented when the actual wound was identified on 11/28/17. The staff further explained that the skin assessments were incomplete and should have been completed by the nurse doing the assessments. Staff 180 also indicated that she had been ill and had failed to complete the facility acquired pressure area CQI/Rick assessment investigation per policy. Staff 180 explained that the CQI/Risk assessment report would have helped the facility identify the root cause to determine the best plan of care for the resident. When asked why Resident 125 did not have a specialty bed to prevent worsening of the pressure ulcer, Staff 180 explained that it was denied initially by Medicare. When a request was made to review the denial letter, none was provided. During a separate interview on 12/14/17 at 10:51 a.m., a nursing administrative staff (Staff 193) validated that Resident 125 did have a stage 3 pressure ulcer which was being taken care of by the wound care team at the facility. Staff 193 indicated that she will look for the Medicare denial letter for the specialty bed. She continued to explain that the resident will be getting the special pressure relieving bed today (on 12/14/17). In another interview on 12/14/17 at 11:12 a.m., a licensed staff (Staff 190) explained that facility staff received inservices on how to conduct skin assessment and are were supposed to report skin concerns immediately to the interdisciplinary team. The staff further explained that the resident did not have the recommended bed due to her lumbar fracture contraindication. Staff 190 stated that the pressure reducing bed will arrive today 12/14/17 and that it was safe for the resident's lumbar fracture. During an interview at 12/14/17 02:12 p.m., a medical provider (Staff 236) stated that Resident 125 was sent out to the hospital because her wound to the buttocks had worsened from the last time she evaluated the wound. The staff confirmed that she was not notified that the wound had worsened until today. Staff 236 described the wound and stated that she can put her fist into the wound bed. In addition the resident was also spiking a fever for the first time since admission. Staff 236 added that the specialty bed was contraindicated for the resident due to her lumbar fracture. When asked who ordered the specialty bed, Staff 236 stated that she was not aware that the bed was being ordered.
F 0689 **Level of harm -** Actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the residents' environment was free of accident hazards to prevent injuries; and that residents received adequate supervision and assistive devices to prevent falls. The deficient practice resulted in actual harm due to falls with injury for five residents (Residents 63, 57, 25, 55, and 24) , and injury related to an unkept assistive device (Resident 51). Findings include: 1. Resident 63 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. Review of the most current MDS (minimum data set) assessment dated [DATE] revealed that the resident had a BIMS (brief interview of mental status) score of 15 (no cognitive deficits), and had no mood or behavior problems. The same MDS noted that the Resident 63 was totally dependent on staff for most activities of daily living requiring 2-plus person physical assist, including bed mobility, transfer, and toilet use, because of functional impairment on both sides of her upper and lower extremities. During an interview on 12/13/17, Resident 63 stated that she had a fall while being transferred from her bed using a lift was transferred to an acute care hospital because she broke her legs. The resident added that the fall caused her a lot of pain and discomfort. Review of an electronic progress note dated 9/26/17 (at 7:10 a.m.) revealed that at 9:00 p.m. on 9/25/17, a licensed staff was summoned to the resident's room and discovered (the) resident kneeling on the floor with 2 staff holding onto her with (R) knee on the Hoyer frame. Accordingly, the staff stated that when the resident was lifted off the bed using the Hoyer, they did not notice that 1 strap came loose from the hook, and the resident slipped out of the sling so they had to lower her to the floor. The same progress note added that the Resident confirmed that she did not fall, only her her (R) knee was resting on the Hoyer frame. While the resident was described to have complained of pain on her right knee, she refused an x-ray examination. Review of the medical record revealed that the attending physician was notified of the fall at 8:37 p.m. on 9/26/17, almost 24 hours after the incident. Further review of the medical record revealed that Resident 63 continued to complain of stiffness and discomfort on her right knee on 9/26/17 (at 8:37 p.m.), and pain on the same knee on 9/27/17 (at 7:22 a.m.). While an x-ray was offered which again was refused, there was no indication that the resident was informed of the benefits and risks of the refusal including further injuries of the right knee. At 10:27 a.m., on 9/27/17, the resident was described tearful during repositioning with 2 staff members present, and stated that her pain level was 9/10 (where 10 is the most severe). At this time, the resident did agree to have an x-ray which was conducted at the bedside at 6:45 a.m. on 9/28/17, about 20 hours after she had consented. On 9/28/17 (at 12:12 p.m.), another progress note revealed that the x-ray indicated abnormal results and that a physician's order was obtained to transfer the resident to the emergency room . Further review of the medical record revealed that the resident sustained [REDACTED]. Review of the care plan for Falls dated 12/01/17 (edited 12/05/17) revealed the lack of indication that the care plan and its interventions were reviewed and revised based on findings following the fall by Resident 63 on 9/25/17. There was no indication, for example, that the need for safety checks were included as part of the protocol for the use of the lift. The care plan also noted that the risk for falls was related to the resident's immobility and that she required extensive-total assistance with care or positioning. The goal was that Resident 63 will not fall or exhibit signs of drug related side effects or adverse drug reaction. Interventions included Hoyer lift for transfer x 2, will monitor fall risk assessment quarterly, assessing/recording the effectiveness of drug treatment; and monitoring and reporting signs of sedation, [MEDICAL CONDITION], or [MEDICATION NAME] symptoms. No mention about the fall on 9/25/17 was made. Review of facility documents about the incident also revealed that while interviews were conducted with several licensed and unlicensed staff, the interviews were directed toward establishing that the resident did not fall but was assisted on the floor, or that she was lowered to the floor. However, according to another interview, the resident had informed a family member that she fell off the Hoyer (lift). Further, while mention was made that 1 strap came loose from the hook of the Hoyer lift (as was noted in the progress note dated 9/26/17), there was no indication that attempts were made to determine how this had occurred including identifying antecedents that allowed this to happen, and the development of corrective actions to prevent future incidents. 2. On 12/13/17 at 8:42 a.m., Resident 57 was observed up in wheelchair in the dining/activity area eating breakfast with the supervision of a certified nurse aide (CNA 211). The resident was alert but confused and had difficulty hearing. He was also observed able to self-propel his wheelchair. The resident's left arm was covered with protective gerisleeves. On the same day at 9:00 a.m., interview with CNA 211 revealed that Resident 57 bumps his arms readily against bedside drawers and other equipment in his room. The resident's room was observed while resident was in dining area. There was no equipment clutter inside the room and the bed linens had been stripped off at that time. Resident 57 was readmitted in the facility on 4/27/16 with [DIAGNOSES REDACTED]. Review of the quarterly minimum data set ((MDS) dated [DATE] revealed a brief interview for mental status (BIMS) score of 00 indicating severely impaired cognitive status. The MDS also revealed the resident did not exhibit any behavioral symptoms. The resident's functional status with activities of daily living include the following: required extensive assistance with one person physical assist with bed mobility, transfer, dressing: and toilet use; required supervision with setup help only for eating; required limited assistance with one person physical assist with personal hygiene and required total dependence on staff with 2+persons physical assist.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 9) Further review of the MDS revealed the resident's balance during transitions from sitting to standing, turning around and moving on and off toilet was not steady and only able to stabilize with staff assistance. His functional range of motion revealed that he has impairment in one side of his upper extremity. The MDS revealed the resident's active [DIAGNOSES REDACTED]. On 12/13/17 at 9:12 a.m. the resident was observed back in his room. where he was assisted by CNA 211 to the toilet. The emergency call light was observed lit up 2 x from the nurses station. Interview with CNA 211 who was standing outside the resident's bathroom stated the resident had a bowel movement (BM) and the resident was the one who pulled the call light cord to request for assistance. The resident was observed in bathroom washing his hands by the sink. CNA 211 stated the resident was continent of bowel and bladder and he can call the nurses when he needed assistance. Review of the annual minimum data set (MDS) assessment dated [DATE] revealed no falls; and the quarterly MDS dated [DATE] revealed one injury but no falls. Review the electronic record revealed that on 12/13/17 the resident acquired a skin tear to the left forearm (LFA). There were no additional documentation to show the cause of the skin tear or any investigation was conducted to prevent further skin tears. Further record review revealed that on 9/20/17 at 6:45 p.m., Resident 57 was found on the floor in supine position between the foot of the bed and his wheelchair behind him close to entrance door. Upon assessment the facility staff found slight redness on he resident's upper back and below the shoulder blade and there was no tenderness when palpated. On 3/3/16 at 2:50 p.m., Resident 57 was observed on the floor. Review of the .[NAME] Hopkins Fall Risk Assessment Tool revealed a result of 11 points indicating the resident was a moderate fall risk. The fall care plans and approaches/interventions were not revised to determine the effectiveness of new approaches formulated. Review of the Events of Fall Incidents for the two unwitnessed falls did not reflect a thorough investigation of both events. This was verified with the facility's nursing supervisor on 12/14/17 at 12:30 p.m. She also confirmed that there was no investigation of the resident's skin tear on the LFA on 12/13/17 after reviewing the Event Report that was initiated but not filled out or completed. She further stated the the interdisciplinary team (IDT) fall packet would contain the investigations. Interview with an administrative nursing staff (Staff 190) on 12/14/17 at 1:30 p.m. revealed that the IDT packets were initiated only last month - November, (YEAR). 3. Resident 25 was admitted [DATE] with [DIAGNOSES REDACTED]. The minimum data set (MDS - an assessment tool) for each of the assessments for the last year showed a BIMS (brief interview of mental status) score of 3 indicating the resident had significant cognitive impairment. The MDS also noted that the resident needed moderate assistance with activities of daily living (ADLs). During a family telephone interview on 12/12/17 at 11:29 a.m., when asked if the resident had ever fallen, the family member stated that she fell at home a lot, and that was why they placed her in the skilled nursing facility. Earlier this year (2017), according to the family member, Resident 25 fell at the facility and that they (the facility) called her to let her know. The family member added that she was told Resident 25 was found on the floor in the night. She had real bad bruises. Her whole left side of her face was bruised. She forgets that she can't walk anymore and then falls. Review of Resident 25's electronic medical record during the survey, under Event, revealed a note dated 11/1/16 at 12:39 a.m. that read in pertinent part as follows: found on floor no pain, said she hit her head. Had reddish knot on right side of head & abrasion to R. (right) elbow. In the PROGRESS NOTES the following read in pertinent part as follows: 4/18/2017 (12:05 AM), On 4/17/17 at (11:35 PM) a CNA found the resident laying on the floor with a bump to the L(eft) forehead, unwitnessed fall, resident alert but confused, stated she 'hurt my head,' assessment done, MD (doctor)and (responsible party) notified, sent to the ER via ambulance. (Resident 25) complained of pain to L forehead. The resident returned to the facility from theER on [DATE] at 12:30 p.m. Progress notes indicated that the (resident) had bruising to under right eye, lump on left forehead, eye and cheek, left eye closed with swelling. Was found to have a UTI (urinary tract infection). (Face) Painful to touch but refused pain medication Monitoring and neuro checks conducted. A care planning conference was conducted with residents family members on 4/20/17; however, there were no changes to care plan and no documentation as to why the care plan remained the same despite the injury the resident sustained [REDACTED].>Review of EVENTS documentation showed only one fall incident report dated 11/1/2016. There was no Event report documented for the 4/17/2017 fall. Review of the facility policy #NSG107.45 titled, .The Caring House Incident Reporting dated revised 09/2017 read in pertinent part as follows: All significant incidents associated with TCH patients . will be documented and reported to the Director of Nursing (DON). A significant incident is defined as any incident that is unexpected or has an unexpected outcome Policy Interpretation and Implementation: .Procedure: 1. Incidents include, but are not limited to: .d. Injuries .resulting from accidents or errors. e. Patient falls when: i) observed (whether injury noted or not), ii) Reported by patient or family (only if patient or nurse feel injury has occurred) . On 12/14/17 at 11:45 a.m., during an interview requesting information on the resident's fall incidents, a medical records staff (Staff 188) provided a care plan for falls that indicated Resident 25 had four falls in the past year on the following dates: a. 10/1/2016 - no information documented; b. 11/1/2016 - no injuries, c. 2/15/17 and 4/17/17 with head injuries. The care plan did not include changes/revision or updates after two of the four falls on 10/1/16 and 2/15/17. On 12/14/17 at 10:43 a.m., when asked if the facility had conducted any fall risk assessment, progress notes, care plan updates, or if any hospital records were available for the falls dated 11/1/16, 2/15/17 and 4/17/17, Staff 188 provided the following; -Fall Risk scores above 10 means the resident was at High Risk for falls. -Fall Risk assessments for the following dates revealed the following scores: -10/14/16 =21; 2/7/17 score =16; 4/7/17 = 24; 7/13/17= 22; 10/13/17= 20; and 11/19/17 = 14. These scores indicated the resident was at continued high risk for falls. Review of the MDS revealed the following in pertinent part: Quarterly assessment dated [DATE] under Section J1700, 1800/1900 indicated the resident had no falls since previous assessment: a care plan for falls was in place with an initial date 1/29/2016. There were no updates after the fall documented on 10/1/2016. Annual assessment dated [DATE] under Section J1800 /J1900 indicated the resident had 2 or more falls with no injuries and 2 or more falls with minor injuries. A care plan was in place with a start date of 11/01/16; however the interventions were the same as on 1/29/16. The goal was not changed even though Resident 25 had four or more falls in the previous look back period. The quarterly assessment dated [DATE] in section J1800/ J1900 indicated the resident had one fall with minor injury since the previous quarter. A care plan was in place with start date of 12/6/15 with revision dated 2/16/2017 - the goal was the same, although the target date had changed to 4/1/17. Further, while, the resident had fallen with a head injury, the facility removed but did not replace the following interventions: utilize pressure sensor when not in bed; provide environmental adaptations; low bed, call light within reach, adequate glare free lighting; area free of clutter; remind resident and reinforce safety awareness; and report to MD side effect associated with resident's medication use. The intervention reminding and reinforcing safety awareness was not relevant to Resident 25 due to her cognitive impairment. The quarterly assessment dated [DATE] under Section J1800/ J1900 indicated the resident had one fall with minor injury since the previous quarter. The fall was dated 4/17/17 and resulted in a head injury. The care plan was in place with the same goals and added intervention to keep personal items and frequently used items within reach; observe frequently and place in

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 10) supervised area when out of bed; occupy resident with meaningful distractions; music, companion, crafts, etc The resident was unable to obtain personal items for herself. The intervention was not meaningful to the resident. The intervention to observe frequently when out of bed did not address the resident falling out of bed. The quarterly assessment dated [DATE] Under Section J1800 indicated the resident had no falls in the previous quarter. The care plan was in place with the same goal; above interventions continued and the facility restarted interventions that had been removed in (MONTH) (YEAR). 4. Resident 55 was admitted [DATE] with multiple [DIAGNOSES REDACTED]. Review of the minimum data set (MDS - an assessment tool) initial assessment dated [DATE] under Section J1700 revealed, Fall History on admission in the last month=(None); Falls in the last 2 - 6 months = (None): Fracture related to falls in the last 6 months prior to admission = (None). A significant change in condition assessment dated [DATE] under Section J 1800 listed, Falls since admission = Yes; and imder Section J1900, number of falls since admission = Two or more; Injury = NONE: Major Injury = Yes. A quarterly assessment dated [DATE] - Section J1800/1900 indicated One fall since 5/10/17 with no injuries: The most recent quarterly assessment dated [DATE] in section J1800/1900 - One fall since 8/10/17 no injury. During the initial tour of the facility on 12/11/17 at 4:05 p.m., the resident was observed sitting in a recliner chair in the main living area with his eyes closed. He had on regular shoes. A licensed staff member (Staff 191) stated that Resident 55 used a wheelchair for mobility. Observation of the resident's room showed a private room with fall mats observed beside both sides of bed, the bed was in an extremely low position. On 12/13/17 at 2:17 p.m., when asked how long she had known and worked with Resident 55, a certified nurse aide (CNA 59) stated she had worked with him since his admission approximately 11 months ago. CNA 59 stated that due to his cognitive impairment the resident did not remember that he could not walk, and that he tried to get up but then would fall down because he was weak. CNA 59 added that facility staff kept a close watch on him even when he was in his room at night; however, sometimes, the staff had to step away and even if it's just for a minute, the resident sometimes would get up and then would fall. When asked what happened when he broke his nose, CNA 59 stated, When he fell and broke his nose in (MONTH) (2017), he had rolled out of his bed. It was in the low position, but we did not have fall mats beside the bed at the time. Right after that the fall mats were placed. During the survey on different days review of Resident 55's medical record revealed the following: In the Matrix electronic health record (EHR) was a section titled EVENTS which are reports of incidents/events that occurred to the resident. A report dated 12/10/17 at 9:00 p.m., indicated the resident fell out of his wheel chair but did not sustain an injury. A review of EHR showed a care plan for falls initiated on 2/8/17 and revised on 12/11/17. Under the Problem indicating that the resident was At risk for falls, a list of falls with the following dates were noted: a. 2/28/17 - no injury (NI). Review of the Progress notes dated 2/28/17 at 9:57 p.m. read that resident was found on the floor and was sent to the emergency room (ER) for evaluation and treatment. Accordingly, the resident returned from theER on [DATE] at 4:29 a.m. The results of the X-ray showed a [MEDICAL CONDITION] elbow. The staff placed the bed in low position; however the care plan was not updated. b. 3/6/17 and 3/11/17- no injury. No details of these falls were found and the care plan was not updated. c. 4/24/17 - listed a witnessed fall and [MEDICAL CONDITION] after the fall. Resident 55 was sent to the ER and was noted to have no injury. d. 5/18/17 - the resident fell and sustained a skin tear to right forehead; e. 5/22/17 - fell out of bed and sustained a laceration and fracture to bridge of nose, and laceration to the upper lip; f. 6/9/17 fell out of bed; however sustained no injury; g. 2/10/17 - most recent fall; fell out of his wheel chair on the way to his room. There were no updates to the care plan for the above falls. On 12/14/17 at 3:48 p.m., during an interview, when asked for the investigation of the 8 falls unrelated to [MEDICAL CONDITION] the resident sustained [REDACTED]. During a concurrent record review of the Event Report and care plan for Fall Risk, Staff 190 stated that when the Event Report indicated the care plan was updated, facility staff listed the date of the new fall on the problem list but did not update the goals or the interventions despite Resident 55 having 8 falls including 2 major injuries and one minor injury. During an interview with another licensed staff (Staff 186) on 12/15/17 at 10:14 a.m., when asked how long she had worked at the facility, Staff 186 stated that she had worked at the facility in her position for about 3 years. When asked how she was trained for the MDS coordinator position, Staff 186 responded that it was an on-the-job training by the previous MDS coordinator. When asked what the she did with the care plans/assessments for falls, she stated that she trained the nursing staff to update the care plan as needed. Staff 186 added that the facility did not have a fall committee or meet after each fall. While the interdisciplinary team (IDT) developed the care plans as a team, Staff 186 explained that they used care plan books for ideas on creating care plans, and that the IDT met every Thursday and discussed the care plans together. Staff 186 added that the nurses should have been updating the care plans after each fall. During a concurrent review of the Fall Risk care plans for Resident 55 and Resident 25, Staff 186 acknowledged that the problem statement for the falls did not list the problem; the goal was not measurable; and the interventions listed were not individualized and did not take into account the residents' cognitive impairment. There were no changes to the goals, or interventions after the falls the residents sustained. This lack of individualized care planning, analysis of the root cause of the falls, and implementation of effective interventions may have contributed to Resident 25 and Resident 55's repeated falls. Review of the policy in place at the time of the above falls titled Falls and Fall Risk, Managing dated from 2001 MED-PASS, inc (revised (MONTH) 2007) read in pertinent part as follows: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation; Prioritizing Approaches to Managing Falls and Fall Risk read in pertinent part as follows: .4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 5. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling until falling is reduced or stopped, or until the reason for the continuation of the falling is identified and unavoidable. 6. in conjunction with the Attending Physician, staff will identify and implement relevant interventions . to try to minimize serious consequences of falling. 5. According to the Resident Face Sheet, Resident 24 was originally admitted to the facility on [DATE]. His pertinent [DIAGNOSES REDACTED]. According to the quarterly Minimum Data Set (MDS), a standardized screening and assessment tool used for long term care residents dated 7/12/17, Resident 24 was cognitively intact. In Section C - Cognitive Pattern, Resident 24 was coded with a brief interview for mental status score of 15 out of 15 (score of 13-15 indicates cognitively intact). Review of Section G - Functional Status, indicated Resident 24 required extensive assistance from 2 staff for transfers and extensive assist from 1 staff for bed mobility, locomotion on/off the unit, toileting, and personal hygiene. Under Section J - Health Conditions, Resident 24 was coded as having falls prior to the previous MDS assessment. Review of the current (active) comprehensive care plan for Resident 24 initiated on 9/2/17 and edited on 12/12/17, revealed that a care plan for falls was initiated due to at risk for fall related injury as evidenced by unsteady gait, right-sided [MEDICAL CONDITION]([MEDICAL CONDITION] or stroke). The care plan interventions included: anticipate needs by frequent rounding, encourage and escort to activities consistent with resident's interests to enhance physical strengthening needs, provide and monitor use of adaptive devices - wheelchair, provide environmental adaptations - low bed, call light within reach, adequate/glare-free lighting, area free of clutter, report to physician any side effect associated with the resident's medications use, use fall risk screen to identify risk factors and restorative nursing aide to treat patient three times a week for 12 weeks for bilateral upper and lower extremity strengthening, transfer and balance training, and pre-ambulation training to improve current level of function.

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 11) The restorative program was not initiated until 11/11/17. In addition, the care plan failed to identify the resident's falls that occurred on 5/24/17 and 9/2/17. Further review of the comprehensive care plan demonstrated a lack of new interventions to prevent falls after the resident sustained [REDACTED]. According to the Event Report dated 5/24/17, Resident 24 had an unwitnessed fall in his room which was related to fatigue, secondary to receiving [MEDICAL CONDITION]. The resident was found on the floor in front of his wheelchair after he returned from having a haircut. The Event Report noted that the resident tried to transfer himself from his wheelchair to the bed without asking for assistance. The report read, It appeared that he must have slid down and was found sitting. The fall resulted in scratches to the resident's right elbow measuring 0.4 cm x 0.4 cm, and 0.5 cm x 0.3 cm. The resident also sustained a 13.2 cm scratch on the left side of his back with no bleeding noted. The wound nurse cleaned the areas and applied [MEDICATION NAME] (topical antibiotic ointment). The resident was noted to have mild pain (uncomfortable, annoying - usually able to carry on with daily routines, socialization or sleep), and he denied hitting his head. Neurological checks were started. The Event Report indicated the resident's care plan was updated. Additional information regarding the fall was found in the Resident Progress Note also dated 5/24/17. According to the Resident Progress Note, the medication nurse discovered Resident 24 on the floor in front of his wheelchair. The resident was asked by staff about what had happened and if he tried to get up and get into bed by himself. The resident replied yea (sic). Resident 24 did not notify staff he needed assistance transferring to the bed prior to the fall. Based on review of the Resident Progress Notes dated 5/24/17 through 5/31/17, there was no evidence the interdisciplinary team (IDT) reviewed the fall, evaluated the need for new interventions, or implemented new interventions to help prevent further falls in accordance with facility protocol (see policy below). Review of the Fall Risk Assessments failed to demonstrate staff completed a fall risk assessment after the resident sustained [REDACTED]. According to the Resident Progress Note dated 9/2/17, Resident 24 had a witnessed fall that occurred during Bingo. The resident slid down slowly from his wheelchair to the floor; he did not hit his head. The resident was noted sitting on the floor in the activity room in between the wheelchair foot rest. Two certified nurse aides (CNAs) removed the footrest, and assisted the resident to sit up in his wheelchair. While no injury was noted; however, one hour later the CNA reported seeing a new scratch on the left side of the resident's body (exact location was not specified). The licensed nurse assessed the area and noted a 22-cm scratch on the left side of Resident 24's body. The area was cleansed with normal saline, was patted dry, and [MEDICATION NAME] ointment was applied. The resident's bed was placed in the lowest position, and the CNAs were instructed to make sure Dycem (no-slip, rubber-like material used to stabilize) was placed in his wheelchair seat to prevent him from sliding down. The resident verbalized understanding. The Progress Note indicated frequent rounds were being done to assist in meeting the resident's needs and that staff would continue to monitor the resident. Additional information regarding the fall on 9/2/17 was found in the Event Report, also dated 9/2/17. Resident 24 was playing Bingo in the activity room with the other residents and slowly slid from wheelchair to the floor, as stated by resident, and he obtained a 22-cm scratch from the wheelchair. The section titled, Follow Up Investigation of Incident had listed under other factors - Other: Specify - patient has the dycen (sic) (Rubber cushion) under the pad. Based on review of the Resident Progress Notes dated 9/2/17 through 9/9/17, there was no evidence the IDT reviewed the fall, evaluated the need for new interventions, or implemented new interventions to help prevent further falls. Review of the clinical record failed to demonstrate staff completed a fall risk assessment after Resident 24 sustained the fall with minor injury on 9/2/17. The resident was discharged to the hospital on [DATE] (unrelated to the fall) and was readmitted on [DATE]. A fall risk assessment was not completed until 9/18/17. The fall risk assessment score was 15, which indicated the resident was at high risk for falls. During an interview with an administrative nursing staff (Staff 190) on 12/15/17 at 10:10 a.m. she reported that she was newly appointed to the position and was unable to speak to the falls that occurred on 5/24/17 and 9/2/17. She reviewed the nursing notes, care plan and event reports related to the 5/24/17 fall and stated that she did not see that any new fall interventions initiated in response to the fall. Additionally, Staff 190 was unable to locate an interdisciplinary note related to the 5/24/17 fall and was unable to find fall risk assessments completed in response to the 5/24/17 and 9/2/17 falls. Staff 190 indicated that the facility identified an issue with falls and moving forward, staff were expected to follow the current policy, which included event reporting and highlighting what happened. The unit managers were to start the investigation, interview patients and conduct a root cause analysis. The unit managers were also to complete a fall risk screen (using the [NAME] Hopki (TRUNCATED)
F 0697 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, facility failed to ensure that pain was managed according to the standards of practice and the resident's goal and preferences for 1 of 15 sampled residents (Resident 125). Finding includes: During an observation concurrent with an interview with a family member on 12/11/17 at 12:00 p.m., Resident 125 was observed screaming extremely loud. In the interview, the family member indicated that Resident 125 was having pain and that her pain was not being managed properly. The family member further indicated that she had communicated this with facility staff but that Resident 125 continues to experience severe pain, and even more pain during care. During an observation concurrent with an interview on 12/14/17 at 10:40 a.m., Resident 125 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. The minimum data set ((MDS) dated [DATE] documented that the resident's 14-day assessment which included a brief interview for mental status (BIMS) revealed a score of 15 which indicated that the resident did not have any cognitive deficits. The resident was observed moaning and groaning while lying in bed on her right side. When asked how she was doing, Resident 125 indicated that staff took a long time to give her pain medications and answering her call light. Resident 125 further explained that at times the waiting was at least 1 hour for assistance. The resident also described the pain as being severe all the time. During a record review concurrent with an interview on 12/14/17 at 10:45 a.m., with a licensed staff (Staff 213), she stated that the resident did not convey that she was in pain during the morning medication pass, but did observe the resident moaning and grimacing. When asked if the moaning was a sign of pain, Staff 213 indicated yes, but did not medicate the resident for pain. Review of the clinical record revealed that the last time the resident had a pain medication was on 12/14/17 at 1:57 AM. During an interview on 12/14/2017 at 10:50 a.m., another licensed staff member (Staff 217) indicated that the resident was assessed in the morning and did not have grimacing and did not indicate that she was in pain. Staff 217 further indicated that resident usually have pain during care due to her lumbar fracture. During an interview on 12/14/2017 at 12:00 p.m., with an administrative nursing staff member (Staff 190), she verbalized that her expectation was for the staff to offer pain medication to the residents when observations of moaning and grimacing were present. Staff 190 added that facility staff will be inserviced on nonverbal pain techniques.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that a resident who required [MEDICAL TREATMENT] received care and services consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences for one sampled residents (Resident 36). Finding includes: Resident 36 was re-admitted on [DATE] the following Diagnoses: [REDACTED]. On 12/11/17 at 3:30 p.m., during the initial tour Resident 36 was observed awake, alert and responsive to questions while sitting in a wheelchair in his room. The resident stated that he goes to [MEDICAL TREATMENT] on Tuesdays, Thursdays and Saturdays on the second shift. He also stated that he usually leaves the facility at around 9:00 a.m. and returns around 2:00 p.m. to 3:00 p.m. He confirmed that the only access site used for [MEDICAL TREATMENT] treatments was the right upper arm fistula. He denied any pain or problems on the access site. On 12/12/17 review of the resident's progress notes, care plan and [MEDICAL TREATMENT] report sheet revealed the absence of

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F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 12) description of the swollen portion of the [MEDICAL TREATMENT]. The communication form between the [MEDICAL TREATMENT] unit and the skilled nursing facility ([MEDICAL TREATMENT] Report) did not reflect an accurate description of the type and location of the resident's [MEDICAL TREATMENT]. This was confirmed by a licensed staff (Staff 166) who reviewed the [MEDICAL TREATMENT] report sheet. Review of the resident progress notes dated 12/07/17 at 11:13 p.m. revealed that the resident removed bandage to arterio-venous (AV) fistula site, bleeding ensued. New pressure dressing applied, instructed resident to leave it on until morning. There was no further description of the amount of or duration of the bleeding episode before it was controlled. There was no further assessment of the bruit/thrill to determine the patency of the access site after the bleeding episode.Review of the resident's plan of care with start date of 1/24/17 revealed a problem of the resident's potential for complications related to [MEDICAL TREATMENT] for [DIAGNOSES REDACTED]. An approach dated 1/24/17 revealed Monitor AV shunt by palpating for thrill and auscultating for bruit every shift. Another approach dated 1/24/17 stated, Protect [MEDICAL TREATMENT] or shunt access site from injury, and avoid [MEDICATION NAME] by clothing or blood pressure cuff on the limb with access device or shunt. With the above bleeding incident and application of new pressure pressure dressing, there was no documentation that the bruit or thrill was checked. Interview with another licensed staff (Staff 191) on 12/13/17 at 3:00 p.m. confirmed the care plans were not person centered to reflect the current description of the aneurysm in the right upper arm access site of the resident. This was also confirmed by the nurse supervisor on 12/14/17 at 10:30 a.m. The high risk for bleeding and clotting of access site were not addressed in the care plan. Review of the resident progress notes dated 11/25/17 at 11:15 a.m. revealed that the resident went to [MEDICAL TREATMENT]. However, [MEDICAL TREATMENT] facility staff phoned the skilled nursing facility (SNF) at 9:54 a.m. that the resident had been Hoyered out of wheelchair and had visible diarrhea on sling/chair. Resident refused to get cleaned up at [MEDICAL TREATMENT], did not want to go through with treatment. [MEDICAL TREATMENT] nurse informed the SNF an attempt will be made to schedule the resident for 11/27/17. However, the Thanksgiving holiday schedule was fixed and the resident not dialyzed until 11/28/17. Review of the resident progress notes showed no documentation of any assessment of the resident's fluid status or any signs and symptoms of fluid overload considering the resident's non-compliance with the prescribed fluid restriction. From 11/25/17 progress notes, the next entry in the resident progress notes was dated 11/30/17. On 12/15/17 at 09:11 a.m. to 09:30 a.m. the [MEDICAL TREATMENT] center was contacted by phone to confirm the resident's missed treatment. The [MEDICAL TREATMENT] Unit Manager verified the resident missed [MEDICAL TREATMENT] treatment on 11/25/17. Confirmed that resident came to the [MEDICAL TREATMENT] unit however, the [MEDICAL TREATMENT] treatment record was marked No Show. There was no documented pre-assessment information. The resident's next [MEDICAL TREATMENT] treatment was on Tuesday 11/28/17 and the resident dialyzed for 3 hours and 20 minutes. The [MEDICAL TREATMENT] treatment prescribed duration was 3 hours and 15 minutes. The resident was hypotensive on last hour with a blood pressure of 92/54. The pre assessment information revealed the resident did not have any shortness of breath nor [MEDICAL CONDITION]. Post [MEDICAL TREATMENT] assessment revealed that the resident was unable to reach his dry weight due to [MEDICAL CONDITION]. The nurse manager confirmed the resident did not have [MEDICAL TREATMENT] treatment for 4 days from 11/24/17 to 11/27/17. Further interview with the [MEDICAL TREATMENT] facility's unit manager revealed that a fistulogram/venogram was done on 11/6/17 due to an incident of prolonged bleeding that week. Treatment records on 11/2/17 and 11/4/17 showed bleeding was prolonged over 10 minutes. This information of prolonged bleeding was not evident in the [MEDICAL TREATMENT] communication record with the facility. During the interview, the [MEDICAL TREATMENT] unit manager confirmed that the resident had an AV fistula, and that he had been on [MEDICAL TREATMENT] since 2008 but started in that unit on 1/14/14. The aneurysm in the right upper arm fistula was due to prolonged use of the fistula and weakening of the venous wall. The unit manager added that the care for the site included: no pressure on the site, no sleeping on it, no BP and no blood draws on the affected arm. The unit manager confirmed that she was not informed by the facility of the bleeding episode that Resident 36 had on 12/7/17.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to maintain sufficient nursing staff with the appropriate competencies and skills to provide nursing and related services to assure safety and attain or maintain the highest well-being of each resident Findings include: On 12/11/17 at 11:46 a.m. during an interview, Resident 51 stated that there was a delay in answering the call light when she needed assistance in toileting especially in the day shift. Review of the Bed Activity Log revealed no significant delay in response to call light. The resident stated that a caregiver entered her room as a response to the call light, turned off the call light and told her the caregiver will be right back, but failed to return to assist her. Therefore, the resident's boyfriend had to assist her to go to the bathroom. review of the resident's medical record revealed [REDACTED]. The resident was observed to be alert, oriented, and responds appropriately to questions asked. On 12/11/17 at 3:00 p.m. during the initial tour, Resident 39 complained that certified nurse aides were slow to respond to the call lights. When asked what she needed, the resident stated that she needed more blankets because she was always cold, especially at night. On 12/12/17 at 10:30 a.m. Resident 7 stated he was not comfortable with non-regular staff aides that care for him because they do not know how to anticipate and meet his special needs. Further interview with an administrative nursing staff (Staff 190) revealed the nursing staffing as follows: regularly from Monday to Friday there will be two unit supervisors that are registered nurses for units A, [NAME] and F and there's one LPN and four (4) CNAs per unit. Staff 190 also stated that for unit B the staffing includes one RN, one LPN and 4 CNAs. Staff 190 further clarified that weekend staffing remains the same: there are two (2) RNs that work every weekend; registry staffing is used after exhausting the facility's PRN nurses' pool that includes three three RNs, six LPNs, and ten CNAs. In addition, the facility has 3 wound care nurses, 3 MDS nurses that includes 2 LPNs and one RN. Staff 190 also indicated that the facility will contract with a new registry company and there will be 10 regularly assigned nurses and aides only for the facility. Interview with the Staff 190 and Staff 191 on 12/13/17 at 5:00 p.m. revealed that registry personnel who had worked in the facility in the past months had not attended the facility's inservices. Staff 190 added that the facility's contracted registry company has been responsible for their employees' training and evaluations. On 12/15/17 at 1:06 p.m. Staff 190 stated that they do have a call light system to gauge the duration of call lights unanswered. There were also cameras in the hallway monitored by security. Review of the QAPI data on staffing revealed that data on the use of registry and number of call offs were started on September, (YEAR). Although the QAPI data were captured for the months of (MONTH) and October, (YEAR) there was no documented analysis or evaluation of the data. There was no threshold set to improve the registry utilization and staffing plans for call offs. On 12/15/17 at 12:39 p.m. during an interview, Staff 190 stated that she got involved with QAPI on September, (YEAR) when she started in the facility in mid September. Review of the Nurse Training log information for the last certification period revealed the lack of update with the new regulations related to abuse policy and dementia care. This was verified with Staff 191 on 12/13/17 at 5:00 p.m. (Cross-refer to F686 and F689)

F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that the resident's drug regimen was free from unnecessary drugs including drugs used without adequate monitoring, indication, or in the presence of duplicate therapy. Findings include:

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F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 13) 1. Resident 56 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed that the resident had no cognitive impairment but was dependent on staff for most activities of daily living. The MDS noted that he had no mood or behavior problems. Review of the medical record revealed that on 11/29/17 a physician's orders [REDACTED]. In addition, another physician's orders [REDACTED]. Further record review revealed that on 11/30/17, another physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. Monitoring flowsheets, however, noted that it was also an antidepressant drug used concurrently with two other antidepressants: Duloxetine and [MEDICATION NAME]. Review of the medical records revealed that while the resident was receiving three antidepressants, there was no documentation to support concurrent use of the antidepressants and why duplicate therapy was to the benefit of the resident in alleviating behavior problems and other symptoms. Further record review revealed that the resident, in addition to the use of [MEDICATION NAME] for [MEDICAL CONDITION], was also [MEDICATION NAME] mgs at bedtime as necessary (ordered on [DATE]). Review of the MAR indicated [REDACTED]. Review of the medical record revealed the lack of documentation to support duplicate therapy and why it was advantageous to Resident 56. During an interview on 12/13/17, a nursing administrative staff member (Staff 190) was informed about the resident's use of [MEDICAL CONDITION] drugs and the lack of documentation supporting duplicate therapy. While the staff member stated that a search will be made, none however was presented for review. Review of monitoring sheets also revealed that while use of the antidepressants (Duloxetine, [MEDICATION NAME]) were for depression, licensed staff did not always identify a specific medical symptom as manifestation of the depression that was being treated. During an interview on 12/14/17, a licensed staff member (Staff 176) stated that the resident had feeling of sadness about missing his family, and that he looks sad. The staff member also added that the resident does not want any of his medications changed and that he liked them the way he had been taking them. 2. Resident 30 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. The most recent quarterly MDS dated [DATE] indicated that the resident had a BIMS (brief interview of mental status) score of 13 indicating intact cognitive ability, and that he just needed supervision for most activities of daily living. The same MDS noted that the resident had no mood or behavior problems and did not have indicators of [MEDICAL CONDITION] such as hallucinations or delusions. Review of the medical record revealed several physician's progress notes, including 6/20/17 and 11/28/17 that Resident 30 had dementia secondary to [MEDICAL CONDITION]. Another progress note dated 10/31/17 indicated that the resident's dementia was stable. Mental health consultation notes dated 8/12/17 and 11/07/17 also described the resident as essentially stable with a [DIAGNOSES REDACTED]. Review of the medical record revealed that Resident 30 had a physician's orders [REDACTED]. The order did not specify a specific behavior problem for the use of the antipsychotic drug. On 10/31/17, the order was changed to 0.5 mg at bedtime for major [MEDICAL CONDITION] verbalization of negative thoughts. On 11/07/17, the [MEDICATION NAME] was further decreased to 0.25. mg at bedtime and Resident 30 continued to receive the medication. While monitoring flow sheets indicated that use of the antipsychotic was for verbalizations of negative thoughts, the flow sheets however did not identify any behavior to support the continuing use of the [MEDICATION NAME]. Flow sheets from 10/31/17 through 11/30/17, as well as from 12/01/17 through 12/14/17, for example, did not document any problem behavior. Further record review revealed the lack of documented indication for the use of the antipsychotic drug. In a separate interview on 12/14/17, a licensed staff member (Staff 176) stated that Resident 30 was started on antipsychotic drugs about two years ago because he was aggressive. The staff member added however that the resident was much better now. 3. Resident 53 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] indicated that the resident had a BIMS score of 15 (indicating no cognitive impairment), had no mood or behavior problems, and required supervision for activities of daily living. The MDS also noted that the resident had a [DIAGNOSES REDACTED]. Review of the medical record revealed that Resident 53 had a physician's orders [REDACTED]. Review of the MAR (medication administration record) revealed that the resident had been receiving the antidepressant as ordered. Further review of the flow sheet administration history which details behavior monitoring conducted by the facility revealed that monitoring was being conducted only from 6:00 a.m. to 6:30 p.m. During an interview on 12/14/17, a licensed staff (Staff 176) stated that behavior monitoring was only being conducted on the day shift because the resident was receiving the antidepressant on the day shift at 9:00 a.m. In a separate interview, an administrative staff member (Staff 190) stated that behavior monitoring should be on a 24-hour basis.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that PRN orders for [MEDICAL CONDITION] medications were limited only to 14 days. Findings include: 1. Resident 56 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed that the resident had no cognitive impairment but was dependent on staff for most activities of daily living. The MDS noted that he had no mood or behavior problems. On 11/29/17, a physician's orders [REDACTED]. Review of the MAR (medication administration record) on 12/14/15 revealed that the resident had received the medication on 12/01/17; from 12/03/17 through 12/08/17, and from 12/11/17 through 12/13/17. Further record review however revealed the lack of indication that the physician (or prescribing practitioner) had documented in the resident's medical record the rationale that continuing the medication past the 14 days was appropriate, as required. 2. Resident 31 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. Review of the medical record on 12/14/15 revealed that Resident 31 had a physician's orders [REDACTED]. According to the record, the medication had been previously ordered on [DATE]. On 8/14/17, a drug regimen review conducted by the pharmacist included a recommendation whether the [MEDICAL CONDITION] medication-ordered on a PRN basis-could be discontinued; or that use of the medication could be extended for another 14 days if the physician were to write a Benefit vs Risk note. Review of the MAR indicated [REDACTED]. While the physician's orders [REDACTED].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, observations and interviews, the facility failed to ensure: 1) expired medications and biologicals

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 14) were removed from use in 1 of 4 medication rooms, 2 of 4 medication carts, 2 of 4 treatment carts, and that 2) 1 of 4 treatment carts was locked when left unattended. Findings include: Policy According to the facility policy titled Gila River Health Care - The Caring House Storage of Medications, last revised 09/2017, revealed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medications storage and preparation areas in a clean safe, and sanitary manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. Unit [NAME] Medication Room An audit of Unit E's medication room was conducted on 12/12/17 at 8:50 a.m. in the presence of a licensed staff member (Staff 166). The audit revealed one opened and used multiuse vial of [MEDICATION NAME] Purified Protein Derivative (PPD) solution (lot number). The used vial of PPD solution had an open date of 7/06/17. The manufacturer's instructions on the side of the medication container revealed the medication should be discarded 30 days after being opened. During an interview on 12/12/17 at 9:00 a.m., Staff 166 acknowledged that the multiuse vial of PPD solution was opened on 7/6/17 and was only good for 28 days after being opened. Unit A Medication and Treatment Carts An audit of Unit A's treatment cart was conducted on 12/12/17 at 9:15 a.m. in the presence of another licensed staff (Staff 162). The audit revealed one tube of zinc oxide ointment with an expiration date of 11/2017 was available for use. During an interview with Staff 162 on 12/12/17 at 9:24 a.m. she acknowledged the expired tube of zinc oxide and removed the medicated ointment from use. Unit B Medication and Treatment Cart An audit of Unit B's medication cart was conducted on 12/12/17 at 9:28 a.m. in the presence of a licensed staff (Staff 163). The audit revealed one box of [MEDICATION NAME] lubricant eye gel with an open date of 9/2015, which were available for use. The expiration date listed on the box of [MEDICATION NAME] lubricant eye gel was 10/2017. There were a total of 16 individual doses available for use; however, two of the 14 individual doses expired on 10/2017. One box of Refresh plus lubricant eye drops was located on top of the medication cart. The expiration date listed on the side of the box was 10/2018. There was a total of 35 individual doses available for use; however, 28 of the 35 individual doses expired on 6/2017. One vial of [MEDICATION NAME] (lot #A7119) with an expiration date of 3/2020 was observed however, the multiuse vial of insulin had an open date of 11/3/17. A second vial of [MEDICATION NAME] (Lot #7F010A) with an expiration date of 12/2019 was observed however, the multiuse vial of insulin had an open date of 11/9/17. The manufacturer's instructions on the side of the vials of [MEDICATION NAME] revealed the medication should be used within 28 days after initial use. During an interview on 12/12/17 at 9:58 a.m., Staff 163 stated that all nurses were responsible for checking the medication carts and that they were checked daily. Staff 163 acknowledged that the mislabeled and expired medications should not have been available for use in the medication cart. Staff 163 acknowledged the expired doses of [MEDICATION NAME] lubricant eye gel, refresh plus lubricant eye drops, and one vial of [MEDICATION NAME] (Lot # A7119) with an open date of 11/3/17. The staff added that [MEDICATION NAME] was only good for 28 days after it was opened. Additionally, Staff 163 pointed out that the [MEDICATION NAME] (Lot # F010A) with an open date of 11/9/17 was for a resident who was recently admitted to the facility on [DATE] and the vial of insulin was mislabeled with the wrong open date. An audit of Unit B's treatment cart was conducted on 12/12/17 at 10:07 a.m. in the presence of Staff 163 and a unit manager (Staff 182). The audit revealed one tube of [MEDICATION NAME] ointment expired on 10/2017 and one bottle of [MEDICATION NAME] 2.25% shampoo expired on 8/2017 were available for use. Staff 182 acknowledged the expired medications. During an interview with Staff 163 on 12/12/17 at 10:07 a.m. she stated that the night shift staff were responsible for checking the treatment carts. During an interview with Staff 182 on 12/12/17 at 10:15 a.m. she acknowledged the expired ointment and medicated shampoo. She stated they should not have been available for use. Unit F Treatment Cart On 12/12/17 at 10:19 a.m. the treatment cart on Unit F was observed outside of room [ROOM NUMBER]. The door to room [ROOM NUMBER] was closed and the treatment cart was observed to be unlocked. There was a sticker across the front of the treatment cart that read, L[NAME]K YOUR CART BEFORE YOU WALK AWAY. There were no residents observed in the hallway. At 10:35 a.m. LPN 182 exited room [ROOM NUMBER]. During an interview with a licensed staff member (Staff 182) at 10:35 a.m. the staff was informed that the treatment cart was left unlocked. Staff 182 seemed surprised and looked down at the locking device on the treatment cart and acknowledged the cart was unlocked. The staff stated that there was even a sign on the front of the cart to advise staff to lock the cart. Staff 182 stated the cart contained treatment items such as barrier creams and medicated ointments. When asked if the cart should be locked, she stated that it was best practice to keep the cart locked. During an interview with an administrative nursing staff (Staff 190) on 12/15/17 at 11:19 a.m., she stated that the pharmacy consultant was responsible for checking the medication carts for expired medications, but she was unable to state how often this occurred. She stated nurses should also check for expired medications on a daily basis and on all shifts for all carts (medication and treatment). She stated the treatment carts should be locked when unattended, because the concern was anyone would be able to get into the cart. She stated that approximately a week ago she put a sticker on the carts to remind staff to keep the carts locked.
F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain dental services for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to provide routine dental services for one of four residents (Resident 13) reviewed for dental services out of a total of 19 sampled residents. Findings include: On 12/15/17 a request for the facility's policy related to dental services was requested; however, one was not provided prior to the end of the survey. On 12/12/17 at 2:50 p.m. and 12/13/17 at 8:10 a.m., Resident 13 was observed to have missing and broken teeth that were dark in color. According to the annual Minimum Data Set (MDS) assessment (a comprehensive assessment completed on nursing home residents), section L (Oral/Dental Status), dated 7/1/17, revealed Resident 13 had obvious or likely cavity or broken natural teeth. (cross refer F791: Emergency/Routine Dental Services) According to the annual MDS' Care Area Assessment Summary (CAAS), related to section L, Resident 13 had natural teeth with some that were missing and broken. Resident 13 was unable to answer any questions and responds by mumbling. Oral care was provided by nursing personnel due to her inability to perform steps to provide her own oral care and she was unable to understand instructions related to her cognition. Due to her advanced age and cognition she will see the dentists as needed as she is unable to follow instructions or cooperate for dental consult. The Dentists will be consulted if resident develops any oral [MEDICAL CONDITION] or ulcerations, difficulty chewing related to oral pain or c/o tooth pain and was on a mechanically altered diet. A review of Resident 13's comprehensive care plans, last reviewed and revised on 10/05/17, failed to reveal a comprehensive care plan for R13's dental status or care (cross refer F656: Develop/Implement comprehensive Care Plan). A clinical record review was conducted on 12/13/17 at 9:11 a.m. and failed to reveal any dental consults for Resident 13. An interview with a family member, familiar with Resident 13's care, was conducted on 12/14/17 at 1:45 p.m. The family member reported Resident 13 used to wear dentures before, which were lost back in 1996. The family member reported that they would prefer that Resident 13 go and see the dentist, as long as she does not act out and would prefer for the facility to at least try and have Resident 13 see the dentist annually.

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F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 15) During an interview with Unit Clerk (UC) 232, on 12/14/17 at 2:59 p.m., she reported that she had only been on the unit for approximately one to one and half years. She stated that the decision for a resident to see the dentist was left up to the family, if the resident was unable to make the decision; however, the family would also need to be present during the visit due to the resident's diagnosis. She stated that this discussion would be entered into the resident's progress notes and care plan. UC 232 indicated that she talked with Resident 13's daughter today (12/14/17), who stated she would like the facility to attempt and send Resident 13 to see the dentist for services. She stated the daughter reported the last time the resident as seen by the dentist was 1997. UC 233 further stated the daughter reported Resident 13 had partials, developed an abscess, and had behaviors and that was the last time she remembered Resident 13 being seen. UC 232 reported that Resident 13's daughter wanted an initial consult for dental services and if Resident 13 was cooperative she would like the facility to continue with the treatment plan; however, if Resident 13 had behaviors or was uncooperative, then it would be ok not perusing dental services ongoing.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on observation, interviews and record review, the facility failed to utilize its resources effectively and efficiently to administer the facility to prevent actual harm for 8 of 19 residents (R8, R24, R25, R51, 54, R57, R63 and R 125). The facility failed to provide a safe environment with adequate supervision to prevent falls with injury (R8, R24, R25, R51, R55, R57 and R63), failed to maintain resident assistive devices to prevent injury (R126). (Cross reference F689) and failed to prevent pressure ulcer development, and provide effective pain management for R125 (Cross reference F686 and F697). These deficient practices lead to the finding of a pattern of actual harm and substandard quality of care to residents. Findings include: During interviews conducted throughout the week of the survey 12/11-15/2017 several staff, and administrative staff stated that the facility had at least five administrators within the last five months. In fact the current administrator is an acting administrator and has been working at this facility for approximately one month. The assistant administrator has been in the position for approximately 5 months. The Director of Nursing (DON) has been in the position for approximately 2 months. On 12/15/2017 before noon, when informed of the above findings of actual harm and substandard quality of care, administrative staff stated that the issue of falls with injury had been identified by the quality assurance program improvement (QAPI) committee; however, there were no changes to the system or changes that had been made by the previous administration were not effective to reduce the severity of injury related to falls. The acting administrator stated that the administrative team was conducting a needs assessment of the facility and identified several areas in need of improvement. During a telephone interview on 12/15/2017 in the morning when asked how the medical director participated in the administration of the facility, the medical director stated that he was the attending physician for many of the residents and participated in the care planning process as well as QAPI. During an interview on 12/15/2017 in the morning, when asked how the governing body was involved in the administration of the facility, the CEO stated that they meet quarterly where the facility provides reports on how things are going. He stated that these reports did not reflect the serious nature of the falls, lack of pain management or prevention of pressure ulcer development. He acknowledged that the facility had difficulty finding a permanent administrator in the past several months; however they have found a permanent administrator now (who started on the third day of the survey) and the acting administrator will stay to work with the new management/administration team to stabilize the facility. Review of the Job description dated 9/2015 and titled: Gila River Health Care Operational Job Description for Position title: SNF Administrator - Caring House read in pertinent part as follows: Position Summary: .Responsible for ensuring the highest degree of quality resident life is maintained .Critical Tasks: .Overseeing staff to ensure the delivery high-quality(sic)services Supervising the work of the nursing home employees .Directs operation of The Caring House to meet State, Federal regulations and avoid violations or licensure decertification .Key Performance Indicators: .Ensures that all employees, residents, visitors, and the general public follow established policies and procedures .Ensures that an adequate number of appropriately trained professional and auxiliary personnel are on duty at all times to meet the needs of the residents . Metrics: . Reviews accident/incident reports, maintain and records an effective accident prevention program . The lack of consistent and effective administration and use of its resources may have contributed to actual harm to patients and the finding of substandard quality of care.
F 0865 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a plan that describes the process for conducting QAPI and QAA activities.** Based on interview and record review, the facility failed to monitor and prevent reoccurrence of high risk concern areas for the resident falls with injuries and facility-acquired pressure ulcers for numerous residents during the Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) committee meetings. Findings include: During a record review concurrent with an interview on 12/15/2017 at 09:00 a.m., with Staff 38, he indicated that the facility is in the process of revising the QAPI/QAA policy. Staff 38, further indicated that he was fairly new to the facility and also recently resigned from his position, but will be training the new administrator on the new QAPI process. Staff 38, indicated that the facility meets monthly for the QAPI committee and all the concerns are being reviewed. Staff 38, was not able to provide any evidence on how the concerns identified are being monitoring and followed up on. A review of the monthly minutes which clearly identified various concerns such as falls, staffing and pressure ulcer/injury with Staff 38 was conducted and he was not able to show any result from QAA committee that improved any of the concerns from the previous months. In addition, the medical director was not added to the list of attendees until 12/12/17 for the QAPI meeting. Staff 38, acknowledged that the issues with falls and pressure ulcers could have been prevented with better monitoring and follow up from the leadership team. During a record review concurrent with an interview on 12/15/2017 at 09:10 a.m., with Staff 225, a request was made to show the past years QAPI committee minutes and she was not able to provide any evidence for (MONTH) (YEAR) to (MONTH) (YEAR). On 12/15/2017 a review of the facility policy titled QAA Committee revealed: Addressing Care and Services - The QAPI program will aim for the safety and high quality with all clinical interventions and service delivery while emphasizing autonomy, choice, quality of daily life for residents and family by ensuring our data collection tools and monitoring systems are in place and are consistence for proactive analysis, system failure analysis and corrective actions. We will utilize the best available evidence (e.g. data, national benchmarks, published best practices, clinical guidelines) to define and measure our goals. Review of the September, (MONTH) and (MONTH) (YEAR) QAPI committee minutes revealed no evidence on how concerns were being monitored at the facility after the QAPI meetings. In addition, the QAPI minutes disclosed no identifying structure or processes which would have prevented the Substandard Quality of Care (SQC) issues identified during the survey.